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**QUALITY OF NURSING AND THE WARD AS A LEARNING ENVIRONMENT
FOR STUDENT NURSES: A MULTIMETHOD APPROACH**

by

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**A thesis submitted to the University of London
for the degree of Doctor of Philosophy**

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ABSTRACT

The research aimed to study the relationship between the quality of nursing and the quality of the ward as a learning environment for student nurses.

Researchers agree on the characteristics which provide a good ward learning environment but attempts to define quality of nursing have proved more controversial. The importance of the nurse's caring role in ensuring quality, and its formalisation through the nursing process, are emphasised by nursing leaders. However, the gap between the professional rhetoric of caring and nurses' own preferences and priorities suggested the need to reassess the concepts of quality of nursing and learning environments in the light of Hochschild's (1983) analysis of emotional labour.

The fieldwork was carried out at a London teaching hospital. A multimethod research approach was adopted, using qualitative and quantitative methods, including participant and non-participant observation in classroom and wards, interviews with students, sisters and patients, and student questionnaires.

Three hypotheses or conceptual clusters were developed from the data and were used to explain the relationship between quality of nursing and learning environments. These hypotheses suggested that quality of nursing and students' ward learning were influenced by: the nature of the work and the learning material; sisters' management styles; and students' personal and learning trajectories.

Findings show that the predominant teaching/learning paradigm held by nurses presupposed that formal teaching was necessary to learning. In the absence of an alternative conceptualisation of nursing, nurses assumed that nursing knowledge was based on medical facts.

Findings also describe perceptions of quality of nursing. Though nurses preferred technical nursing and valued it as learning material, they also identified the importance of their physical and emotional labour to patients. Patients judged quality of nursing by the emotional style in which it was given, irrespective of diagnosis and technical care requirements. Similarly, students judged the quality of the learning environment by the sister's emotional style of management. In conclusion, the relationship between quality of nursing and ward learning is articulated through the sister's emotional style of management.

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CHAPTER 1

INTRODUCTION TO THE STUDY

This study arose from a longstanding interest in the dual and potentially conflicting role of student nurses as learners and as principal care givers. Previous research had shown that, in British hospitals with nursing schools, as much as 75 per cent of direct patient care may be provided by nurses in training (Moore and Moulton 1979). This statistic confirms what is well known: that students constitute the main work force in British hospitals. Their status as learners is based on twin assumptions that trained nurses teach in the ward and students learn as they work (Fretwell 1982). Since students work in the wards and learn as they nurse it could be inferred that there is an association between the learning environment and quality of nursing on a ward. Revans (1964), for example, suggested that hospitals with high morale had effective communication systems, 'good ward atmospheres', a stable nursing workforce and rapid patient recovery. Orton (1981) specified the characteristics of 'good ward atmospheres' or 'learning climates' and proposed that students and patients benefited from ward sisters who were interested in team work and consultation, and who were aware of subordinates' needs. Orton concluded that on wards with 'good' learning climates '... not only did students see their own physical and emotional needs amply met, but also those of the patients' (p.61).

Other researchers confirmed the importance of positive working relationships between permanent ward staff and students in creating a good learning environment (Fretwell 1982, Lewin and Leach 1982, Ogier 1982). Ward specialty has also been identified as an important variable.

Attempts to define quality of nursing have proved more

controversial. On the one hand, quantitative researchers believe that quality of nursing can be operationalised into objective measures of patient care (Wandelt and Ager 1974, Jelinek et al 1974, Goldstone et al 1983). On the other, qualitative researchers such as Evers (1982) suggest that the 'essence' of quality is a relative concept which defies quantification. Hawthorne (1974), in a study of nurses' activities in paediatric wards, also identified the lack of a universally accepted definition of quality of nursing. In the light of the literature on the hospital care of children, Hawthorne selected 'consideration of the emotional needs of young patients' as a necessary component of quality of nursing.

An early British study recognised that nurses' work included 'affective' as well as 'technical' and 'basic' components (Goddard 1953). Affective nursing was defined as meeting the patient's psychosocial and, by implication, emotional needs. Basic nursing was described as the care of patients' physical needs, and technical nursing referred to nurses' work associated with the medical treatment of disease.

McFarlane (1976) believed that the categorisation of nurses' work in this way led to an undervaluing of their role in caring for patients' affective and basic needs by attributing higher status to technical nursing. McFarlane asserted that nursing was about 'helping, assisting, serving, caring' rather than working as doctors' assistants. In a later paper McFarlane (1977) promoted the nursing process as a way of formalising the caring role of the nurse, particularly in relation to its affective and basic components, by providing a methodology for organising nursing knowledge and practice and improving patient care.

Armstrong (1983) noted a reinterpretation of the nurse's role in general nursing textbooks, following the introduction of the nursing process. Patients were no longer described in strictly biological

terms. Psychology and communication skills were emphasised and 'subjectivity' and emotions entered the nurse-patient relationship.

Macleod Clark (1981), in a study of verbal communication between nurses and patients, found that despite the rhetoric of the nursing process patients' emotional needs were inadequately met.

Recent studies of nurse training found that students valued technical nursing and saw basic nursing as low status work (Fretwell 1982, Melia 1982, Alexander 1983). Affective or 'social' nursing was described by Melia's students as 'not really nursing'.

Thus, the literature illustrated a gap between the professional rhetoric of caring and nurses' own work priorities and preferences. Not only have nurse leaders and educationalists failed to grapple with the gender divisions of labour within the health service but also to acknowledge the conceptual complexity of care and its relationship to women's work. The importance of the emotional component of caring and its relationship to the power relations within an institution are raised in Hochschild's analysis of emotional labour in the USA airline industry (Hochschild 1983).

On the basis of the findings outlined above, the present study aimed to reassess the concept of quality of nursing and explore the way in which it related to the learning environment in a variety of wards and from a number of nursing and patient perspectives. The study also investigated the extent to which the nursing process and communication skills had become part of the practice and learning of nursing. The subjective experiences of students as learners and principal carers, at different stages of training, were also described.

Hochschild's definition and analysis of emotional labour in the work place was used as a conceptual means to understanding the emotional complexities of the nursing labour process and the training and supervision of students in school and ward.

The Research Setting and Subjects

The setting for the study was a large teaching hospital and school of nursing (referred to as the 'City' hospital) in Central London.

Although a hospital had been on the site since 1755, the present building was rebuilt and reopened between 1929 and 1934. At the beginning of the study, the hospital had a total of 558 beds distributed across 27 general and specialist wards. Forty per cent of the beds were designated as general medicine (106) and surgery (114).

Students were allocated to a combination of 14 out of these 27 wards during their three year training. They could also be allocated to specialist wards in the 'Women's Hospital' (gynaecology) and longstay geriatric hospital. They spent time in the operating theatres and the accident and emergency departments of either the study hospital or a neighbouring teaching hospital (referred to as the 'County' hospital). The school of nursing was located in a building opened in 1963 and adjacent to the main hospital.

General training was offered for admission to the Register of the General Nursing Council of England and Wales (GNC)* granting state registration (SRN) on successful completion of the course. A variety of integrated general, specialist and academic courses were also offered at City school of nursing, such as sick children's nursing, Diploma in Nursing, Degree in Nursing and Degree in Social Science and Administration.

The study focused on students admitted for RGN training only. During the study period, the integrated courses offering degrees and the diploma were gradually phased out. The six annual intakes of students

* The GNC which regulated nurse training was reorganised in 1983. Its functions were taken over by national boards, including the English National Board (ENB) as part of the United Kingdom Central Council of Nursing, Midwifery and Health Visiting. The SRN qualification was renamed RGN (Registered General Nurse).

to RGN training were also reduced from 540 (1981) to 450 (1983) to 360 (1984).

In the period prior to and at the beginning of the study period there was no difficulty in recruiting students for RGN training with the General Certificate of Education in a minimum of five subjects at 'O' level and evidence of 'A' level study. Two per cent of the students had university degrees.

Six times the required number of applicants applied for training and approximately half that number were interviewed. Towards the end of the study period the number of applicants for training decreased. The reason for the decrease appeared to be associated with the uncertainty surrounding the City hospital and nursing school as a result of economic cutbacks and reorganisation of resources reported in the national and local media. It is important to bear in mind these changes, and their effects, as a backdrop to the main study.

The City hospital and its nursing school were chosen by the researcher because of the interest and concern of the chief nursing officer in improving nurse training. The immediate trigger for her concern was an unfavourable report which recommended a change in the 'total dependence on learners' as the principal workforce in giving patient care. The report stated that the hospital employed too few auxiliary nurses and ward clerks in the wards, and that students worked excessive hours of night duty.

The researcher was employed as a senior nurse (research) by the health authority to undertake the study over a three year period.

It was decided to narrow the study to medical nursing in the first and third year of training. Four medical wards were chosen as case studies for the exploratory and indepth studies. A first and third year group of students (two sets, 20 and 30 students respectively) were observed during classes in the school of nursing. A number of them were

also interviewed. In addition other first and third year students and trained nurses were observed and/or interviewed on the four study wards. A total of 392 first and third year students completed questionnaires following allocation to 12 medical wards.

Particulars of the wards studied are as follows:

PARTICIPANT OBSERVATION AND QUESTIONNAIRES

<u>NAME OF WARD</u>	<u>OFFICIAL DESIGNATION</u>	<u>NO. OF BEDS</u>
Edale	Male - general medicine (including endocrinology)	14
	Geriatrics	2
Windermere	Female - general medicine (including respiratory medicine)	18
	Geriatrics	2
Ronda	Male (3-4 female) - general medicine (including gastroenterology)	14
	Geriatrics	9
Kinder	Female - General medicine	4
	Cardiology	9
	Geriatrics	2

QUESTIONNAIRES

Langdale	Female - general medicine (including endocrinology)	17
	Geriatrics	3
Ullswater	Male - general medicine (including respiratory medicine)	15
	Geriatrics	2
Coniston	Female - general medicine (including gastroenterology)	10
	Rheumatology	3
	Geriatrics	6
Ambleside	Male - general medicine	9
	Cardiology	7
	Geriatrics	2
Loughrigg	Male/female - neurology	15
	Neurosurgery	9
Eskdale	Female - radiotherapy (oncology)	19
Wastwater	Male - radiotherapy (oncology)	14
Buttermere	Female - radiotherapy (oncology)	20

Further ward particulars are given in chapter 5, section 5.1.

In February 1985 the bed allocation on the medical wards changed. All the designated geriatric beds in the hospital were concentrated on Edale and Langdale wards.

Details of the nurses and patients interviewed and/or observed are given in chapter 3, section 3.3.2. The following terminology has been adopted. 'Student' refers to nurses undertaking the three year RGN course. 'Trained' nurse refers to sister and staff nurses, all of whom have a minimum qualification of RGN. Nurse teachers/tutorial staff are generic terms used to refer to registered nurse tutors (RNT) and registered clinical teachers (RCNT). Any other 'nursing' terms are referenced by footnotes in the body of the text where they appear.

The fieldwork for the study was conducted during the period January 1984 to June 1985. January to June 1984 was used as an exploratory period for preliminary observation and interviews in the wards and nursing school of City hospital. Three months were spent on the first study ward (March-June 1984). In the indepth study (July 1984 - June 1985) 14 contact weeks were spent in the nursing school and 8 weeks on each of three study wards.

A multimethod research approach was adopted using a variety of data collecting techniques, including document analysis, questionnaires, interviews and participant observation. A modified version of grounded theory (Glaser and Strauss 1967) was at the heart of the approach in that data were gathered, handled and analysed as the study progressed, in order to develop and explore working hypotheses related to the research problem.

The study is reported in nine chapters. A review of the literature follows this introduction, in chapter 2. Chapter 3 presents methodological perspectives underlying the multimethod approach and the research procedure from which the data were generated. The subsequent

findings are presented in chapters 4-8.

Each of these chapters addresses different issues related to the conceptualisation and exploration of the relationship between quality of nursing and the ward learning environment. The interaction between students' stage of training, quality of nursing and ward learning is considered throughout the presentation and discussion of the findings.

In chapter 4, the organisation of nurse training at the City school of nursing in relation to its form and content is described. The dual activities of nursing patients and learning nursing, in the context of different ward environments, are considered in chapters 5-8.

In chapter 5, the learning environment is described according to the nature of nursing work and the learning material generated by different patient populations on different wards.

Chapter 6 presents data on sisters' ward management styles and interpretations of the nursing process, in order to discuss the implications of both for quality of nursing and student learning.

In chapter 7, approaches to conceptualising quality of care and the relative status of its basic, technical and affective components (Goddard 1953) are illustrated through the data.

Chapter 8 considers additional learning material and processes experienced by students whilst caring for patients.

Conclusions, implications of and recommendations from the findings for nursing practice and training are presented in chapter 9.

CHAPTER 2

REVIEW OF THE LITERATURE

Quality of nursing and the ward as a learning environment are two distinct and extensive research areas. It was necessary to review the literature relevant to both areas but also to be selective. For example, the quality of nursing literature on measurement has included North American references to supplement the comparatively few studies undertaken in this country. In contrast, the extensive British based research literature on teaching and learning of nursing permitted the exclusion of North American references.

As the literature review falls into these two distinct areas described above, this chapter has been divided into two corresponding sections. A third section reviews those studies that have explored the association between quality of nursing and learning to nurse. A final section presents the theoretical issues raised by the literature and developed in the present study.

2.1 The Quality of Nursing

The extensive literature available on quality of nursing is reviewed under the following subsections: (2.1.1) the nature of nursing; (2.1.2) the measurement of quality; and (2.1.3) qualitative approaches to quality issues in the study of longstay institutions.

In the subsection on the nature of nursing, literature is reviewed which addresses general issues concerning nursing's history, professional status and rhetoric as presented by nursing leaders and educationalists. A number of studies, undertaken to assess the extent to which the nursing process has been implemented in relation to the rhetoric, are also reviewed. Other studies are reviewed which contribute to an understanding of the personal and organisational

complexity involved in communication and interpersonal relationships between nurses and patients. The review also extends to studies of practitioners' and lay perceptions of nurses and nursing and other forms of paid and unpaid care work. The studies of care work offer complementary frameworks for understanding the nature of nursing and highlight the limitations of the professional rhetoric.

The second subsection, on the measurement of quality, reviews the relevant literature in terms of the underlying theoretical frameworks and methods used to measure quality of nursing, including patient dependency and workload and quality assurance.

The reasons for the growth of quality assurance in North America and dependency studies in Britain are discussed.

A review of qualitative approaches to quality issues shows that researchers involved in studies of institutions have explored the concept of quality of care as received by patients/clients. But rather than seeking definitive measurements of quality of care alone, these researchers have investigated wider organisational factors that affect patient outcomes. Some of these studies also incorporate the patient's/client's perspective on care. It is interesting to note that a significant number of these studies concentrate on the so-called 'cinderella' services of psychiatry, mental and physical handicap, and care of the elderly.

2.1.1 The nature of nursing

A review of the literature on the nature of nursing illustrates the complexity of the subject. A paper by Oakley (1984) in which she elaborates the question 'What is especially important or distinctive about nursing?' demonstrates this point well. In attempting to answer this question, Oakley seeks answers from historical, sociological and feminist sources, some of which will be considered in more detail below.

For example, the diversity of nursing's origins and activities and its equivocal status as a 'profession' are central to an understanding of its nature. The historical origins of nursing offer some explanations for the characteristics of the profession today. In mid-nineteenth century Britain 'it took the form it did because nursing was able to meet a social need: to provide a suitable occupation for the daughters of the higher social classes' (Abel-Smith 1960). Most of these women were unmarried and worked only in the prestigious voluntary hospitals. The first training school was established by Nightingale in 1860. The predominant ideology was one of 'vocation' and devotion to duty (Williams 1978). Hours were long and the pay low. In this way the nurse adhered to her rightful place and the qualities of obedience and subservience were encouraged as befitted a victorian lady. Her relationship to the doctor, a man, was one of subordination (Carpenter 1977).

The conditions in the publicly owned institutions were different. The poor law infirmaries housed the chronic sick and the nurses were often paupers themselves. In 1865 they were described as 'a very inferior set of women' (Dean and Bolton 1980). The nursing services developed slowly since trained nurses preferred to work in the voluntary hospitals. The mental asylums were perceived as having even lower status than the poor law infirmaries. They were staffed by male attendants, employed for their physical capabilities in restraining violent patients. The hospital nursing specialties which exist today had their origins in these nineteenth century institutions, namely general nursing, psychiatry, care of children and the chronic sick and elderly.

It is evident, therefore, that nurses today do not constitute a homogenous group, since their ideologies and activities reflect their historical origins. For example, the teaching hospitals

continue as the prestigious medical centres where nurses tend to be middle class, female and white. The non-teaching, psychiatric and longstay hospitals for the elderly and mentally handicapped more often employ nurses who are working class and non-white, with a higher percentage of male and untrained nurses (Abel Smith 1960, Bellaby and Oribabor 1980).

Nurses are not a homogenous group who readily meet the conventional criteria of a profession laid down by sociologists. Freidson (1970), for example, describes the elements of professionalism as control by the occupational group of knowledge, recruitment and education, regulation of standards and practice and an orientation towards public rather than individual service.

According to Freidson (1970), nurses as part of the medical division of labour can never be completely professionally autonomous. The reason for this, following Freidson's analysis, is that the nurse's knowledge and skills revolve around the diagnostic and treatment model of cure. Many nursing tasks must be authorised by doctors who also control the admission of patients and their treatment. In the public's eyes nurses are seen as doctors' assistants rather than as practitioners in their own right. On the other hand, they rely on being part of the medical division of labour for their claims to being professional. The fact that doctors are predominantly male, and nurses female, enhances the image of dependency. Oakley (1984) develops further the gender issue within nursing by stating that being a nurse is synonymous with being a woman, which 'can be counted as both the weakness and the strength of nursing as a profession'. Oakley's contribution to an understanding of the nature of nursing in the context of women and care work will be discussed later.

Bucher and Strauss's (1961) definition of a profession is more applicable to nursing, in that they point out the existence of 'many

entities, many values and many interests' within occupational groups. They define professions as 'loose amalgamations of segments pursuing different objectives in different manners'. Melia (1984), whose study is discussed in more detail below, uses Bucher and Strauss's characterisation of a profession to explain the continuing divisions between the education and service segments within British nursing.

Over the last decade, nursing leaders in Britain have followed their North American counterparts in adopting the rhetoric of caring as distinctly nursing work. The rationale underlying the rhetoric appears to be to promote nursing as a profession with a body of knowledge and practice distinct from that of medicine. McFarlane, one of the first British professors in nursing and head of Manchester University's department of nursing, gave two influential papers which are examples of the rhetoric of care (McFarlane 1976,1977). In the first paper, she presented 'a charter for caring' to the Royal College of Nursing (RCN); in the second, she presented a 'theory' for nursing to a conference for teachers of integrated and undergraduate degree nursing programmes (AIDCN).

The first paper was a clear exposition of the central role of 'caring' in nursing. Reference was made to Henderson's activities of daily living and 'the unique function of the nurse' described in the document 'Basic Principles of Nursing Care' written on behalf of the International Council of Nurses (ICN) (Henderson 1960). Orem's (1971) 'self-care' or daily living activities were also referred to. On the strength of these two nursing 'theorists' and the consensus view of the North American based Nursing Development Conference Group (1973), McFarlane (1976) claimed that nursing was about 'helping, assisting, serving, caring' rather than the stereotype of the nurse as the doctor's assistant involved in cure. She also drew attention to the Briggs report, which in 1972 had declared nursing and midwifery to be

'the major caring profession'.

McFarlane discussed the meaning of the words 'nursing' and 'caring' and maintained that they have similar roots:

Caring signifies a feeling of concern, of interest, of oversight, with a view to protection. Nursing means ... to nourish and cherish'. (p.189)

McFarlane regretted an earlier job analysis of nursing which had categorised the nurse's work into either 'basic' or 'technical' activity (Goddard 1953). 'Basic' work was consequently relegated to unskilled activities undertaken by junior staff and relatives. The 'technical' work, which was seen as more 'prestigious' and 'complicated' and associated with medical treatment, was reserved for more experienced and senior staff. Consequently, because of this categorisation nurses would fail to appreciate the skill and complexity involved in undertaking so-called 'basic' tasks such as bathing an aphasic patient with a stroke. For this reason, McFarlane believed that the 'caring role must be pre-eminent'.*

McFarlane did not refer to the nursing process in detail in that first paper (1976). But within a year in her second paper she gave a full exposition of the nursing process as the 'unique amalgam that makes nursing theory' (McFarlane 1977). In the intervening years until the present the status of the nursing process as a 'theory' of nursing has been challenged, as discussed later.

McFarlane outlined the observational and interviewing skills required by the nurse to practise the nursing process. Repeated practice was recommended until it (the process) 'becomes part of the nurse's approach and repertoire'.

* Fretwell (1982) has pointed out that Goddard, who led the job analysis team, merely formalised the distinction between basic and technical nursing rather than creating it. The distinction originated not from Goddard's categorisation but from the nature of nursing and the hierarchical way in which it was organised.

In the same year as McFarlane's statement on the nursing process, the General Nursing Council (GNC) (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, UKCC, after 1983) adopted the nursing process as the framework for the general nurses' training curriculum. The nursing process was also used as the basis for setting standards of nursing care promoted by an RCN working group (RCN 1980,1981).

In 1982, McFarlane and Castledine from the Manchester University department of nursing published a textbook which, as its title denotes, served as 'A Guide to the Practice of Nursing using the Nursing Process' (McFarlane and Castledine 1982).

By 1985 McFarlane remained firm in her view that nursing was a 'practice discipline'; that its 'special domain is the daily living or self care activities contributing to health'; and that 'education for nursing needs to be soundly grounded in those skills and sciences that give insight into human functioning' (McFarlane 1985, p. 269). However, McFarlane was doubtful that the present nurse education system, despite its stated commitment to the nursing process (GNC 1977), was adequate to put into practice what she had outlined.

In spite of McFarlane's pessimism, both in 1977 when she had noted the lack of nursing theories and concepts underpinning nursing curriculum design, and again in 1985 as stated above, changes in the way nursing is conceptualised have taken place.

Armstrong (1983), in an analysis of the content of general nursing textbooks, observed that since the introduction of the nursing process in the late seventies there had been a shift in how the nurse's caring role was interpreted. According to Armstrong, until that time patients and, by inference, nurses were prevented from acknowledging and expressing their emotions. The nurse's primary caring role was strictly concerned with the patient's biological functioning. But since the

introduction of the nursing process, nursing textbooks have emphasised the importance of psychology and communication skills and 'subjectivity' has entered the nurse-patient relationship.

Armstrong's paper was too early to note the rapid increase of nursing textbooks and videotapes dealing with the teaching of interpersonal and communication skills associated with the practice of the nursing process since the beginning of the eighties (see Kagan, Evans, Kay 1986 for a current review of the literature available).

However, as stated above the nursing process no longer holds the status of a 'theory'. Roper, Logan and Tierney (1985), authors of a nursing model bearing their name (1980, 1981, 1983) which was developed and refined from the original Roper nursing model (1976), give the following explanation for the change in status of the nursing process: 'It was the wider application of the process in practice which confirmed for many nurses that the process is merely a method of carrying out nursing, but does not shed light on what comprises nursing' (p. 20).

Changes in the conceptualisation of nursing are also indicated by the content of the curricula of the Diploma in Nursing and undergraduate and postgraduate degrees, and a series of articles in the 'Nursing Times' on nursing models and theories aimed at showing how they can be used 'to create an informed basis for the use of the nursing process'. The series of articles has now been published in a book (Aggleton and Chalmers 1986). The 'theories' in current use in nursing curricula and referred to in these articles are described by Riehl and Roy as 'conceptual models for practice' (see Riehl and Roy 1980).

Webb (1984a) discovered in the United States that not only had the nursing process been superseded in many hospitals by nursing diagnoses and standardised, computerised care plans, but nurse educationalists

had 'grave misgivings' about nursing 'theories'. According to Webb, these 'theories' are now referred to by the more modest term 'conceptual framework'. Webb also points out that these frameworks 'amount to no more than a collection of unverified assumptions which reflect the personal philosophies or value-systems of their authors'.

Similarly, in Britain, no substantive research has been undertaken to 'test' the viability of these 'frameworks' in the empirical reality. Miller (1985a) describes the difficulties encountered by experienced nurses in relating nursing theories and models to their own practice both verbally and in using them to write case studies for the Diploma of Nursing. She attributes these difficulties to the broad and abstract nature of the 'theories' and the complex language in which they are couched rendering them conceptually remote from practical reality. These nursing 'theories', therefore, appear to offer limited insights into the nature of nursing as experienced in the everyday world of nurses and patients.

The nursing process appears to be more successful in this respect. A number of articles on the nursing process serve as illustrations of its application to nursing practice (see Miller 1985b). The articles recount its introduction and use by nurses in a variety of settings but no systematic attempts are made by these authors to evaluate its impact.

The medical profession's public criticism of the nursing process serves as an indicator of its application to the reality of the medical hierarchy and the power base of health care (Dopson 1983, Mitchell 1984). Doctors' critical reaction is based on the view that nurses appear to be setting themselves up independently from doctors as the 'patient's advocate' and principal care giver. The authors agree that whilst this approach may be relevant in a long stay geriatric ward, it may be less appropriate in an acute surgical unit. Furthermore, they

are critical of the lack of empirical evidence available to justify the claim that the introduction of the nursing process will improve patient care.

Indeed only a limited number of studies have been undertaken in either the United States of America (USA) or Britain to assess the nursing process in terms of improved understanding and working methods for nurses and better patient care. The studies reviewed below have been selected to illustrate the dialectic between the rhetoric and the empirical reality in defining the nature of nursing. The implications of the nursing process for improving the quality of nursing are discussed in section 2.1.2. (For fuller reviews of the nursing process see De la Cuesta 1979, Keyser 1985, Brooking 1986.)

De la Cuesta (1979) carried out a content analysis of the literature available on the nursing process in the USA and Britain. She also studied hospitals in both countries where it was reputed to have been implemented and interviewed nurses for their views on its implementation. De la Cuesta found that there were variations in its interpretation which she ascribed to cultural and political differences in each country. For example, by the time the nursing process had been introduced to Britain, the active participation of patients in their care, specified in the USA nursing process, was interpreted as one of 'co-operation' only. Furthermore, De la Cuesta concluded that in Britain the nursing process was more likely to be seen as a method to improve nurse satisfaction and patient care rather than a professionalisation strategy as described in the US literature.

She also found that practitioners in both countries tended to adapt and model the nursing process to their own work reality and preference. De la Cuesta's findings suggested that there was a conflict between the theory and practice of the nursing process and a failure to implement it in the way prescribed. In Britain, nurses continued to prioritise

physical rather than psychosocial care. The prioritisation of care in this way was reinforced by a tendency to increase staffing levels on the morning shift with its underlying assumption that the patient's physical needs were greatest at that time; also that psychosocial needs which were continuous did not require similar numbers of staff to deal with them throughout the day. Nurses continued to value routine and approach patients to carry out specific 'tasks' rather than initiating interpersonal communication. They also resisted committing themselves to the elaboration of detailed care plans possibly for fear of being held accountable for omissions of care.

Pembrey (1980), in a study which set out to examine the role of the ward sister, developed the notion of the 'management cycle'. The cycle consisted of stages which included work planning, prescription, delegation of responsibility, retrieval of information and feedback, and making nurses accountable for the care they gave. An integral part of the management cycle was a regular round made by the sister to each patient so that she could personally assess their care. Pembrey observed 50 ward sisters and found that only 9 of them managed the nurses on their ward using each stage of the management cycle. She also found that it was only on those nine wards that patient care was individualised. Inferences were drawn from this finding that the practice of individualised care as prescribed by the nursing process was associated with sisters who used stages of the management cycle to manage the nurses on their ward. Thus, Pembrey's findings inferred that successful implementation of the nursing process had not been achieved and depended most on the ward sisters changing their management style. Pembrey also assumed that the quality of care was better on those wards where the sister used the management cycle and practised individualised care. She did not, though, 'test' her assumption. However, Evers (1981a), in a later study of work organisation in geriatric wards,

found that there appeared to be an association between sisters who used the management cycle and more 'personalised' patient care.

Barnett (1982) used patient care plans on wards where the nursing process had been introduced to monitor written instructions against actual nursing activity undertaken. There was frequently a discrepancy between the two, often because of inadequate supervision of learners in giving 'basic' care since the trained staff were fully occupied with 'technical procedures'.

Keyser (1985) evaluated the impact of the new curricula of the Diploma of Nursing (see above) and the Care of the Elderly Postbasic nursing course on the practice of the nursing process in four wards of four hospitals. Keyser's findings suggest that the implementation of the nursing process and the redefinition of the caring role of the nurse is limited in the absence of supportive education programmes and a redistribution of power and control between patients and nurses, nurses and nurse managers, and nurses and doctors.

Macleod Clark (1981) in a study of verbal communication between nurses and patients in Britain found that, despite the rhetoric of 'total patient care' encapsulated by the nursing process, patients' emotional needs were not being adequately met. An analysis of videotape recordings showed that nurses used verbal strategies to discourage or block communication. The resulting conversations were for the most part superficial and stereotyped. These findings are consonant with those of De la Cuesta's, namely that nurses did not initiate and develop interpersonal communication with patients. Macleod Clark suggests that the reasons nurses behaved in this way might be explained by subconscious role modelling and the lack of systematic training in interpersonal skills. She concludes:

There can be few more potentially telling indicators of the standard of nursing care which patients receive than the quality and quantity of the communication which occurs between nurses and patients.
(p.18)

Smith (1986) offers additional explanations for nurses' deficient communication with patients. In an action research project in a geriatric hospital, Smith found that lack of staff continuity and low staffing levels militated against close longterm relationships between nurses and patients. Even on the rare occasions when staffing levels were favourable, nurses appeared to maintain their distance from patients. Smith explains this distancing behaviour as either a conscious or subconscious strategy to avoid specific stresses involved in providing care for aged and dying patients. Both Smith (1986) and Macleod Clark (1981) refer to Menzies' thesis that such behaviours may be subconsciously developed in order to protect nurses from patients as people rather than the objects of a set of tasks:

The nursing service attempts to protect her (the nurse) from the anxiety (of her relation with the patient) by splitting up her contact with patients ... The total workload of a ward or department is broken down into lists of tasks, each of which is allocated to a particular nurse. (Menzies 1960,).

Menzies' thesis suggests that the introduction of the nursing process with its emphasis on patient centred care may remove the protection that is provided by a task orientated system of care.

However, Taussig (1980) illustrates through a case study from the United States that using the nursing process is no guarantee that nurses will become more emotionally involved with patients. Rather, they develop alternative strategies in place of task allocation for maintaining distance with patients.

Taussig refers to the nursing process using the Subjective (patient's perception) Objective (health worker's observation) Analysis (interpretation of data) Plan (of care), or SOAP formula. Cormack has applied the formula to the British setting and added an additional category 'Evaluation' (Cormack 1980). In his case study, Taussig demonstrates how the patient's subjective perceptions of her emotional and physical condition are reinterpreted by doctors and nurses into

their 'objective' views.

In one incident, for example, the patient who had complained of pain and inability to urinate (the nurses claimed that she could) became so angry that she threw a cup of coffee at the nurse (according to the doctor); on the floor (according to the nurse). The nurses called the doctor, who referred the patient to a psychiatrist and sedation was prescribed. The incident was recorded in the nursing kardex omitting the patient's 'subjective' view of the problem. The 'objective' or nurse's assessment of the problem recorded that the patient was 'very upset' because 'someone' had told her that she should get out of bed to use the commode. In her anger she had thrown a cup of coffee on the floor, said 'dirty words', cried and wanted her husband.

The analysis of the problem was that she was 'very upset' and the subsequent plan recorded that the doctor was notified. On being visited by the doctor the patient was told to 'calm down, since she's not the only patient on the floor'.

Taussig extends his explanation for this behaviour beyond the need of staff to protect themselves against emotional involvement to professional and lay 'disputes over power and definitions of illness and degrees of incapacity'. Hence, in Taussig's view:

... the critical issue centres on the evaluation of incapacity and of feelings such as pain and following that on the treatment necessary. Here is where the professionals deprive the patients of their sense of certainty and security concerning their own self-judgement. (p.9)

Consequently the patient's perceptions of her condition and needs were overruled and the staff's 'objective' assessment of both determined the care she received. Both medical and nursing staff succeeded in maintaining 'professional' distance and also control in the way in which they reacted to a very distressed patient.

Kelly and May's (1982) literature review and theoretical critique of the nursing, sociological and psychological research into the notion of

'good and bad' patients confirms Taussig's interpretation of nurse-patient interactions.

In their view, much of the research is limited on empirical, methodological, epistemological and theoretical grounds for its failure to take into account the complex social relations and symbolic meanings of patient-staff interactions. Taussig's case study is clearly an exception. Hence, patients are defined as 'good' or 'bad' depending on the legitimation they give to the nurse's role.

The literature mistakenly depicts patients as passive recipients or objects of labels and care, rather than determinants, during their interactions with nurses. Kelly and May suggest that:

... the role of the caring nurse is only viable with reference to an appreciative patient ... The good patient is one who confirms the role of the nurse; the bad patient denies that legitimation'.

They conclude that problems in nurse-patient relationships require more than 'simplistic prescriptions' to overcome them since they are 'endemic in social interaction itself'. That the nursing process may be used as 'a simplistic prescription' to overcome these problems is implied by Taussig's case study.

Strauss et al (1982a) contribute further perspectives to an understanding of communication deficits between staff and patients. They point out that the classic picture of the acutely ill patient, lying 'passive and acquiescent' in the hands of doctors and nurses, is an inaccurate characterisation of the increasing number of chronically ill patients who are actively involved in their care. Strauss et al (1982a) suggest that a

... clear recognition of patients' work as part of the total division and organisation of labour could result in a decrease of tension and conflict between patients and staff. (p.977)

Strauss et al's discussion is based on earlier research findings from a study in the US of death and dying (Glaser and Strauss 1965). It was found that the sentimental order of a ward ('sentimental' in the sense

that nurses are involved with 'alive, sentient, reacting objects') was associated with the number of deaths expected to take place there. Hence involvement with patients was encouraged on those wards with low expectation of death. However, because death was an infrequent event and because nurses had become involved with patients, they were observed to be extremely upset if any of them died. On wards which cared for cancer patients or intensive therapy units where the death rate was high the sentimental order of the ward discouraged patient involvement. Nurses learnt to maintain their composure during the dying process and transfer their involvement to the patient's relatives.

The conceptual development in a subsequent study (Strauss et al 1982b) from 'sentimental order' to 'sentimental work' and 'patient work' described above offers further possibilities for defining the nature of nursing. Sentimental work is defined as 'an ingredient of any kind of work where the object being worked on is alive, sentient, reacting'.

Sentimental work is deemed a necessary ingredient either to carry out physical and technical work effectively or because of humanistic considerations. Sentimental work is conceptualised within the context of the technologised hospital and encounters between doctors, nurses, patients and their relatives.

Strauss et al describe seven categories of sentimental work generated from data collected during field observations and interviews. They believe that their typology is useful for specifying the 'conditions, consequences and tactics' of the much used but vague terms of 'psychological work' or 'working psychologically' with patients.*

* These categories included: (1) interactional work and moral rules, (2) trust work, (3) composure work, (4) biographical work, (5) identity work, (6) awareness context work, and (7) rectification work. Certain types of sentimental work are done more by nurses, such as (3), (4) and (5); other types by doctors, eg. (2).

In their study, the disease category of the patient was important for the type of sentimental work it generated. The illness trajectory of the patient is defined as the total organisation of work undertaken during the course of that illness. The trajectory involves different kinds of medical and nursing actions, different skills and resources, depending on different illnesses. Different tasks are distributed amongst workers and involve two types of relationships: one instrumental; the other expressive. Instrumental relationships are involved in carrying out physical and technical tasks with the patient. Expressive relationships concern their affective or psychosocial care.

The nature of sentimental work changed according to what was wrong with the patient, their individual illness trajectory and the predominant ward ethos. Sentimental work was circumscribed by the medical specialty of the ward although 'there are moments and phases in trajectories' such as terminal illness 'when the staff recognise this work is very pertinent'. Sentimental work therefore was not necessarily included in trajectory work. Neither were staff held accountable for doing it.

Often the work was carried out on an individual ad hoc basis and consequently remained invisible unless reported back verbally or in a written report. Even so, other staff members were observed as not perceiving sentimental work as a priority, either because they were too involved in performing physical and technical tasks or they did not recognise its relevance to patients with certain illness trajectories.

One major shortcoming in Strauss et al's analysis was that they did not examine why some health workers chose to do sentimental work and others did not, nor the emotional processes involved in undertaking such work. A second shortcoming of their work is that it is not gender-specific. However, their contribution to an understanding of the nature of nursing lies in their classifications and descriptions of

sentimental work and the conditions under which it takes place at ward level in the technologised hospital.

Given the findings of studies reported above, it is hardly surprising that Fretwell (1982), Melia (1982) and Alexander (1983) found that student nurses categorised their work in a way that McFarlane had feared in her charter for caring, i.e. 'basic' nursing as low status work and 'technical' nursing as prestigious work. The data yielded from questionnaires on learners' perceptions of ward learning opportunities in a study undertaken by Fretwell suggested that students rated 'highly technical procedures' as a necessary part of their training whereas 'routine basic work' was not. According to Fretwell, students were socialised by trained staff into believing that technical work was more important than basic work.

In Alexander's study, only 5 per cent of students commented on 'theory-practice' situations which could be categorised as 'affective' nursing (i.e. caring for patients' psychosocial needs), whereas 53 per cent commented on 'technical' nursing. Similarly, Melia found that students classified patients who required predominantly 'social' care as 'not really nursing'. These studies will be referred to in more detail below (section 2.2).

Kelly and May's (1982) extensive review of the research on 'good and bad' patients is also of relevance here. Through the literature, they illustrate that certain illnesses, diseases and symptoms are more or less popular with doctors and nurses as are perceived patient characteristics of age, gender, race and perceived social class. The most popular are young patients with prospects of full recovery in response to specific medical and nursing skills, techniques and specialties.

Furthermore, a study by Anderson (1973) showed that doctors rated nurses' technical competence as the most important attribute of a 'good

nurse' rather than their ability to provide emotional support. Inferences may be drawn that since nurses are subordinate to doctors in the medical division of labour it is likely that they will be influenced by medical values in prioritising technical rather than 'basic' nursing activities.

In the same study Anderson also found that nearly half the nurses who were asked what they found 'most satisfying' about a day on the ward referred to satisfaction associated with completing 'tasks'. Only a third associated satisfaction with patient comfort, talking to patients and seeing them recover.

However, as a study by Lentz and Michaels (1959) showed, the work preferences and orientations of (trained) nurses differed according to the specialty in which they worked. Hence, medical nurses were found to be more skilled in nurse-patient relationships whilst surgical nurses were more technically skilled.

Yet the main work of a nurse is identified by both the public and new entrants to nursing as primarily concerned with people orientated care rather than cure (MacGuire 1966). A Nursing Times special report carried out at the beginning of the present study showed that the goal of new nursing recruits was 'patient-orientated care' (Holmes 1983). Coser (1962), in asking patients in the US to describe the 'ideal nurse', found that they identified the nurse's essential task as giving personal reassurance and emotional support. Anderson's British based study ten years later also found that patients (and nurses) placed emotional support at the top of their list of what they required of a 'good' nurse.

As the historical account at the beginning of this chapter demonstrates (section 2.1.1) and Oakley (1984) reiterates, these views reflect nursing's origins which are not 'associated with a curative model of health and illness, but with a caring and environmental one';

also that being a nurse is synonymous with being a woman. Thus as Oakley observes, attitude surveys show that 'alertness to the needs of others is consistently picked out as the mark of a good nurse. It is also the mark of a good woman'.

A Department of Health and Social Security (DHSS) recruitment poster in use in 1984, when the present study was beginning, reinforces this view of the nurse as caring woman. The poster showed a small girl in a nurse's uniform bandaging a teddy bear accompanied by the slogan 'The best nurses have the essential qualifications before they go to school'.

Thus, as a review of the literature illustrates, a gap exists between the professional rhetoric of caring and the practice of the nursing process and the empirical reality. Yet the public and to a lesser extent nurses themselves, especially at the beginning of training, recognise the contribution of affective care to the wellbeing of the patient.

As already suggested by the literature, the gender division of labour within the health service and the power relations between doctors (predominantly men) and nurses (predominantly female) offer some explanation for this gap between the rhetoric and the reality. Not only have nurse leaders and educationalists failed to grapple with these issues but also to acknowledge the conceptual complexity of defining care and its relationship to women's work.

The feminist literature offers important insights for understanding why nursing, particularly in relation to 'basic' rather than 'technical' care, continues to be regarded as low status work; also why nurses appear deficient in their ability to communicate with patients and give the emotional support so valued by the public.

Oakley (1984), referring to Miller (1977), points out that women's psychology and social roles are based on the assumption that women

serve others and derive fulfilment from this activity. Thus, by implication, the 'basic' aspects of nursing like any care work is taken for granted as something that women automatically do and enjoy doing.

Ungerson (1983a, 1983b) has contributed to the debate on women's work and care skills by drawing attention to women's unpaid and unrecognised contribution to the maintenance of the Welfare State. Referring to the 'cycle of care', Ungerson describes how women may be involved throughout their lives in caring for others: a child, a husband, a sick, handicapped or elderly relative. Feminist sociologists have pointed out that women's involvement in caring is neither unskilled nor part of society's natural order. This argument is of relevance to an understanding of why certain nursing work is regarded as 'basic'. Ungerson goes on to discuss that care work is 'imbued with sex-role stereotyping' and may be devalued because of this.

Feminist research such as that undertaken by Oakley (1974) on housework has shown that through the experience of their sex roles women have accumulated a significant knowledge base that is largely unrecognised by society at large. However, Oakley's female interviewees were of the opinion that 'mothering and housewifery constitute a set of skills'.

In Ungerson's view (1983b) the process and skills of mothering and caring have much in common. She itemises these skills in the following way:

1. Time available at short notice and in flexible lumps;
2. High levels of skill in domestic tasks - e.g. cooking, cleaning, washing;
3. High levels of social skill, for example talking and listening in order to assess present and future needs;
4. Skills in information gathering about other services and ability to manipulate them on others' behalf;
5. Ability to act autonomously over a wide range of tasks of widely differing skill level;
6. Punctuality and reliability;
7. Ability to operate over long periods in fairly isolated circumstances, engaging in routine and often unpleasant tasks, particularly in the case of the very old, the mentally handicapped

and mentally ill - very little measurable 'success' and positive response from the client.

Ungerson describes these items as the 'socially expected attributes of women' in Western Europe. They also comprehensively describe the attributes expected of nurses and give insights into the nature of nursing.

Parker's (1980) work, outlined by Ungerson (1983b), is also of relevance to an understanding of the nature of nursing and care work. It is pointed out that there are two fundamental features of care work: caring about and caring for. It is suggested that caring 'for', which is task-orientated, is more accurately described as 'tending'. This would appear to be an important distinction for nurses to make since caring about and caring for someone are different in that the concepts do not share the same affective base and are not logically linked. Thus, it is possible to care for a person without caring about them. The reverse also applies.

Having suggested that mothering and caring skills have much in common, Ungerson examines the appropriateness of the notion of 'motherhood' as a model for 'tending'. Drawing on the work of Evers (1981b), she concludes that the 'mothering' model is inappropriate as a care model for the elderly and mentally handicapped since it may lead to treating adults like children. Men appeared to be more accepting of the mothering model of care than women as they were more likely to be used to being serviced by their wives. The work of Evers is described in more detail below (see section 2.1.3).

The issues of the emotional component of caring and its relationship to the power relations within an institution are raised in Hochschild's analysis of emotional labour in the airline industry in the USA (Hochschild 1983).

Hochschild's findings are based on interviews with flight attendants and observation of their recruitment, training and work activity in one

major airline. Additional data were collected from other airlines and service sector industries such as supermarkets and a bill collecting organisation.

Referring to Bell (1973), Hochschild notes that the growth of the US service sector industry (including health) or 'people jobs' has meant that 'communication' and 'encounter' have become the central work relationship. Hochschild estimates that a third of all such 'people jobs' subject their workers, particularly women, to substantial demands for emotional labour. About fifty per cent of all employed women are involved in such work.

Emotional labour as a concept is used by Hochschild to look at what 'people jobs' actually require of workers and the nature of their labour. She identifies jobs with people as being made up of distinct components: physical, technical, mental and emotional labour.

Some service sector jobs, such as the work carried out by flight attendants, are subject to social engineering and organisation on the part of employers so as to ensure the production of significant amounts of emotional labour.

Emotional labour is defined by Hochschild as:

... the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place. (p.7)

The emotional style of offering the service is part of the service itself and in the case of flight attendants is related to the quality of the service on which the airline is judged. The employees' ability and willingness to do emotional labour, therefore, has important financial implications for the company.

According to Hochschild, jobs which involve emotional labour share three characteristics:

- 1) Face to face or voice contact with the public;
- 2) They require the worker to produce an emotional state in another, e.g. gratitude, fear;

3) They allow the employer through training and supervision to exercise a degree of control over the emotional activities of the employees.

Hochschild does not object to the production of emotional labour by employees but rather the underlying system of remuneration that raises the question of its personal cost. Flight attendants undergo a rigorous selection procedure followed by an intensive training programme. They are trained to suppress anger and other negative emotions as well as to accept being treated badly by passengers. Methods comparable to 'deep acting' are utilised.*

Hochschild observed that older, more experienced workers were better at deep acting. The acquisition of this technique allowed them to distinguish between themselves and their 'work' selves. They consciously chose when to act or not and what sorts of acting strategies to employ (i.e. surface or deep).

According to Hochschild the development of these techniques allowed the workers to develop a 'healthy' estrangement between self and work role and prevented 'burnout'. The problems arose when the company set up conditions that made emotional labour impossible to deliver, such as a significant reduction of staff and a quicker turnaround of flights.

The company's rationale is that the flight attendant is well paid to provide emotional labour. Supervision of emotional labour is indirect since it relies on the attendant's judgment of whether passengers will complain to the management when emotional labour is withdrawn.

It is Hochschild's view that flight attendants are undergoing a process of deskilling during their training programmes to do emotional labour. Thus their personal repertoire of feelings and reactions in encounters with passengers become circumscribed by their training

* Strategies for doing emotional labour are defined as 'surface ' and 'deep' acting; 'surface acting' is defined as 'feigning a feeling', 'deep acting' as thinking oneself into a feeling. Deep acting is a technique developed by Stanislavski in his New York drama school.

programmes. Instead of reacting spontaneously to a given situation 'the overall definition of the task is more rigid and the worker's field of choice about what to do is greatly narrowed' (p. 120).

The notion of emotional labour can usefully be related to nursing in the British National Health Service (NHS) and offers important insights into understanding the complexity of the nature of nursing as care work.

Drawing on Hochschild's definition and analysis of emotional labour outlined above, the job of nursing is clearly 'people work'. It is also a predominantly female profession. Nursing satisfies two of the three characteristics of jobs that involve emotional labour, namely face to face contact with the public and the production of an emotional state in another.

The third characteristic, training and supervision by the employer to produce emotional labour by the worker, is more difficult to translate directly to nursing in the NHS.

However, as shown above, the professional rhetoric and the public perception of nursing expect nurses to do emotional labour. Thus, nurses are expected to suppress and induce feelings to maintain an outward appearance that makes patients like passengers feel cared for in a convivial, safe place. It may be inferred and is confirmed in section 2.1.2 below that, as with the airline, the emotional style in which the service is given is part of the service itself. Thus the quality of the service on which a hospital and its workers are judged relate to the emotional style in which the service is given.

The pressure on nurses to maintain quality through the emotional style of their service is not supported by the rigorous training programmes to which flight attendants are subject. Nor is the level of their salary motivated by the commercial interests of management as in the airline industry. Since nurses in the NHS are low income workers it

might be inferred that unlike flight attendants they are not paid to do emotional labour.

Hochschild's notion of emotional labour is particularly useful for looking at the organisational context which shapes the content and emotional style of patient care at both an individual and group level.

The notion of emotional labour bears conceptual similarities with Strauss and colleagues' notion of sentimental work, in that both are used to focus on rather than marginalise the affective or psychosocial elements of 'people jobs'. In the hospital, unlike the aircraft, the trajectory is of a much longer and uncertain duration and according to Strauss et al (1982b) the focus on sentimental work shifts under certain conditions. They also examine the influence of the medical division of labour on the identification of sentimental work and expressive relationships between nurses and patients. Hochschild (1983) takes the analysis further by examining the strategies employed by individuals for doing or withholding emotional labour; and the commercial and remunerative implications attached to its production.

Strauss and colleagues (1982b) observe that sentimental work is not always identified by health workers as a necessary ingredient of interactions with patients, nor are they held accountable for doing it. Emotional labour, on the other hand, is recognised by airline companies as essential to flight attendants' successful work with passengers. Training and supervision are therefore introduced by employers to ensure that their workers undertake emotional labour.

In conclusion, emotional labour offers a more comprehensive theoretical framework than sentimental work with which to analyse the nursing labour process. Thus, emotional labour is used as the main conceptual framework in the present study to describe and explain the quality of nursing and the ward as a learning environment for students and their interrelationship. Sentimental work is used as a way of

describing the types of emotional labour that nurses undertake.

2.1.2 Measuring quality

Extensive literature reviews exist on measuring the quality of nursing (see for example Giovannetti et al 1984, Willis and Linwood 1984). The majority of this literature is from the USA where the motivation to monitor quality emerged as a feature of a complex private health care system. The combination of rising costs, profit making, consumer satisfaction and patient litigation in a rapidly expanding health industry resulted in the foundation of organisations such as the Joint Commission on Accreditation of Hospitals (JCAH) in 1952 and the Peer Review Organisation (PRO) in 1982 which replaced the much earlier Professional Standards Review Organisation (PSRO). Both organisations demand evidence of quality assurance programmes especially in hospitals (Lang and Clinton 1984).

Such demands have led to the development of a variety of techniques for measuring the quality of health care in general and nursing in particular. The development of techniques developed slowly during the fifties (for example, Abdellah 1958) but accelerated during the sixties. A number of quality measuring techniques were published during the seventies and are still in current use. The most notable of these are reviewed later.

In Britain, the findings of the first study which attempted to analyse hospital nursing was published in 1953 (Goddard 1953). As discussed above (section 2.1.1) it was the classification of nursing into basic and technical duties which was condemned by McFarlane (1976). Basic nursing was defined as those duties having their origin in the physical needs of the patient (p.27); technical nursing as all nursing tasks that are concerned with the treatment of disease from which the patient is suffering (p.37); and an additional category not mentioned by McFarlane, namely 'affective' nursing duties concerned

with patients' psychosocial needs (p.28).

The method of investigation was a 24 hour coverage for a period of seven days in each of 26 wards. Data analysis showed the percentage of nurses' time spent on 'basic', 'technical' or 'affective' duties and in direct patient contact. No attempt was made to describe the quality of care given.

During the 1960s a number of studies were undertaken to measure patient-nurse dependency or the amount of nursing time required by patient need (Barr 1967, SHHD 1969, Rhys-Hearn 1972). These studies used activity sampling techniques which were popular in industry at that time (Barnes 1964). Again the emphasis was on quantification of nursing activities rather than quality of care.

The studies were motivated by a new approach to industrial management apparent in Britain at that time, with its emphasis on providing services in the most cost effective and efficient way. The most influential of these studies was the work undertaken by Barr (1967) in Oxford based on previous studies developed at the Johns Hopkins Medical Centre in the USA. Since nursing salaries were said to be the largest single item of hospital expenditure in 1965, Barr's concern was to 'establish what proportion of the available resources should be allowed to nurses and how nursing staff can be employed with maximum efficiency' (p.1).

In order to look at the deployment of nursing staff, Barr developed criteria for allocating patients to three dependency categories based on the underlying assumption that certain patients would require more nursing time than others. The criteria were developed from a three year observation period and systematised into a nursing care form. The form consisted of items related to the patients' basic, or functional, and technical needs. The nursing time required for patients in each category was calculated on a ratio of 1:2:5, based on his observations,

for low, medium and high dependency patients respectively. In other words, it took twice as long to care for a medium dependent patient than one in the low dependency category and five times as long to care for highly dependent patients. By using these ratios according to the number of patients in each category, it was possible to calculate a work load index for each ward. The Barr dependency checklist was adapted for use in the present study and is described in this context in chapter 3.

The Aberdeen Formula (SHHD 1969) was also used as a classification system of patient dependency based on basic and technical needs. Patients were allotted to one of five categories and an allowance was also made for non-direct nursing care associated with administrative and technical duties. Rather than apportioning time to each dependency group, the Scottish research team worked out the average nursing time required in 24 hours for patients in each group. High dependency patients were said to require eight hours, medium dependency patients four hours and low dependency patients 40 minutes, in each 24 hour period. These timings were verified by later studies (e.g. Sutton 1979) and are used in the present study (see chapter 3).

Rhys Hearn (1972) undertook studies addressing dependency factors in detail. The factors included emotional dependency, confusion, immobility, obesity, frailty and incontinence. The aim of Rhys Hearn's studies was to predict staffing requirements in different specialties. She also took account of the different skills mix amongst nurses.

These studies and others reviewed by Wilson-Barnett (1979) went some way to looking at the process of nursing by attempting to define workload and patient dependency and to prescribe optimum staffing levels. However, they were limited by their static view of nursing based on task orientation with an emphasis on physical needs and a medically orientated approach to nursing. This approach assumed that

the clinical specialty shaped nursing practice. Neither did the majority of the studies take into account the levels of nursing skills available. This observation is of particular importance in Britain, given the high percentage of direct patient care given by nurses in training (Moore and Moulton 1979) and allowance made for teaching and supervision required. This latter point is discussed in more detail below (section 2.2.2). Other important limitations of the studies were that no allowance was made for fluctuations in the work load, staff fatigue or time spent on personal activities away from patients (see Coser's (1963) findings discussed below in section 2.1.3). They also failed to identify the nurse's unique responsibility for patient care and to take into account changes in medical and nursing practice.

The former Ministry of Health (1966) recognised the limitation of patient-nurse dependency studies particularly in relation to their lack of qualitative content. Consequently, the RCN was invited in 1966 to set up a project to develop measures for assessing the quality of nursing. The project subsequently made a significant contribution to the field during its lifetime (1966-1975).

An extensive literature survey was compiled and 12 studies designed to train nurses as researchers, to use the findings for developing assessment criteria. Unfortunately, the last phase of the project was never completed but important lessons were learnt for measuring the quality of care. Inman, who was project leader at the conclusion of the study, states:

I do not believe that the problems of measuring the quality of nursing care will ever be solved by examining only specific areas of nursing care. The patient admitted to a hospital ward experiences a total system of nursing care, and sooner or later we must face the problem of how care given on a ward basis is to be assessed. (Inman 1975, p.111)

Inman also saw the need for such studies to address the three

components of the quality assessment framework: context, process and product, together rather than separately. This framework is comparable to the structure-process-outcome framework developed by Donabedian (1966) for evaluating the quality of medical care.

The first category, 'structure', equivalent to Inman's category of 'context', refers to the provision of resources necessary for adequate delivery of nursing care, such as adequate staffing levels, equipment and buildings. The second category, process, refers to the actual delivery and evaluation of nursing care, encapsulated by the nursing process. Outcome or 'product' as defined by Inman (1975) refers to the effects of the nursing care on the patient. The RCN working committee on standards of nursing care has also employed Donabedian's framework (RCN 1980, 1981).

More recently, Kitson (1985) promotes a conceptual framework or model of nursing to develop quality care measures. In a study of the hospitalised elderly, she developed measures based on key concepts related to the nurse's primary caring function and a positive approach to the health of old people to test how they came together to enable the nurse to provide therapeutic care. Her methodology included questionnaires to ward sisters which rated their therapeutic function, in addition to ward based observations. Kitson found that the combination of methods permitted her to show that quality of care seemed to be critically related to the sister's questionnaire score which rated her conceptual approach to caring for the elderly. Observation alone would not have permitted her to reach this conclusion.

The theoretical and methodological complexities involved in developing quality care measures are highlighted by Giovannetti and colleagues in an extensive review of North American quality assessment instruments in nursing (Giovannetti et al 1984). As they point out,

most instruments are either designed to measure process or outcome and rarely a combination of both. It is interesting to note the lack of progress in this respect given Inman's observation of the lack of integration in assessing the three components of care simultaneously, in the RCN studies, nine years previously.

Of the 300 articles spanning 25 years reviewed by Giovannetti and colleagues, only 35 per cent were research based. They were concerned primarily with the development of measuring instruments and only latterly with exploring the theoretical constructs that underpin the notion of quality, as illustrated by Kitson's work on the therapeutic nursing function, discussed above. Three process instruments mentioned by Giovannetti et al are being used on a small scale in Britain. These include the Quality Patient Care Scale (Qualpacs) (Wandelt and Ager 1974), the Phaneuf Nursing Audit (Phaneuf 1976) and Monitor, the Rush-Medicus Nursing Process Methodology (Jelinek et al 1974) adapted for use in Britain (Goldstone et al 1983).

In a recent text, 'Measuring the Quality of Care' (Willis and Linwood 1984), Jacquerye from Belgium states that only five methods for evaluating quality of care globally are available at the present time and all are North American. In addition to three process instruments described by Giovannetti et al (1984) and mentioned above, Jacquerye describes two outcome measures, criterion measures of nursing care quality (Horn and Swain 1977) and méthode d'appréciation de la qualité des soins infirmiers (MAQSI) published by the Order of Nurses of Quebec (Chagnon et al 1982). Jacquerye gives a summary of each of the methods and their underlying conceptual framework. She also evaluates their theoretical and/or methodological approaches and their appropriateness to assessing care in different settings. A brief outline of each instrument discussed by Jacquerye is given here.

The process instruments

The Phaneuf nursing audit assesses the quality of nursing care through an appraisal of the nursing process as documented in the records of discharged patients. A trained nurse reviewer examines the records checking for 50 items subdivided into seven nursing functions such as carrying out doctors' orders, observing patients' signs and symptoms, supervision of patients and carers, promotion of physical and emotional health by direction and teaching. Judgements on the quality of care are made on the basis of the documentation and are classified as 'excellent', 'good', 'incomplete', 'poor', or 'unsafe'. The method is retrospective and does not involve direct observation of nursing care.

The Rush-Medicus/Monitor system is based on a nursing process framework and consists of over 200 criteria applicable to a variety of specialist care settings. The criteria are divided into four sub-lists according to different patient dependency levels. Each sub-list is structured around four sections: planning nursing care, meeting physical needs, non-physical needs (psychological, emotional, social) and evaluation of nursing care. Information is obtained on each ward that is observed, in order to construct a profile of policies, staffing levels, procedures and support services. Patients are classified according to dependency and nursing activities are directly observed and recorded. Questionnaires are completed by a trained nurse observer to assess 'objectively' the level of care being given and the assessment includes an examination of patient records and patient interview. Staff are also given questionnaires to rate their levels of work satisfaction. The system can be computerised (Goldstone and Ball 1984). The methodology provides a comprehensive assessment of the quality of care but requires considerable resources in terms of both personnel and time.

The QualPacs instrument

The Quality Patient Care Scale (QualPacs) aims to measure the multidimensional concept of quality of nursing care (Wandelt and Ager 1974). The instrument was developed from the Slater Nurse Competency Scale in the early 1970s at Wayne State University College of Nursing (Wandelt and Stewart 1975). Non-participant nurse observers trained to use the QualPacs scale observe patients for a two hour period. A further one to two hours is spent before and after the observation period collecting data from case notes, nursing records, patient charts or listening to nurse handover reports. Information is also collected about staffing levels and patient dependency to put randomly selected patients (up to five) into a ward context. The scale covers six dimensions and 68 items of nursing care relating to physical and psychosocial care of the patient, staff communication and professional implications. Each item is accompanied by cues which give guidance as to the underlying concepts of quality for each item. All nurse-patient interactions are observed and rated on a five point scale. The standard of care expected is that of a first level (newly qualified) staff nurse. At the end of the observation period each patient is awarded a mean score between 1 and 5 points. This score is the result of the sum and average for dimensions and items rated against nursing care observed.

QualPacs was selected for use in the present study. The rationale for selecting this instrument and a detailed discussion of its structure and use in the field is presented in chapter 3.

The outcome instruments

Criterion measures of nursing care quality

Horn and Swain (1977) adapted Orem's nursing framework (1971) based on a description of self-care patient requirements for assessing nursing care outcome. The measuring instrument constitutes 539 items

which may be applied to patients classified into 90 groups depending on their medical diagnosis. The patient is used as the primary data source involving direct observation and interviews by nurses trained in the techniques. According to Jacquerye the method has not been fully explored.

MAOSI

The norms and criteria of the quality of care measure developed by the Order of Nurses of Quebec also uses Orem's conceptual framework. Jacquerye favours the method compared to some of the others described above because of its applicability to a range of hospital populations and specialties and its clear definition of nursing's contribution to quality of patient care. Nurses are trained to use the method through interview, data coding and analysis.

Discussion of theoretical issues

It is Giovannetti's (1984) and her colleagues' view that 'virtually all process instruments developed to date are in need of extensive validity testing particularly in relation to the concepts of quality' that they purport to measure. When combinations of process instruments were used in conjunction, scores did not strongly correlate. For example, if QualPacs gave a high score, suggesting quality was high on a ward, the Rush-Medicus gave a significantly lower score (Ventura et al 1982). The same was true when the Phaneuf formula was measured against QualPacs (Ventura 1980). What these results suggest and all nurses intuitively know is that quality of care is a complex multi-dimensional concept. Giovannetti et al (1984) go on to caution: 'Designing instruments to measure quality of health care is an exceedingly complex undertaking and should not be underestimated'. For example, most quality instruments purport to measure total performance across the range of care from best to poorest, as with Qualpacs. However, it may be more meaningful to reduce the number of items within

dimensions to those that are most sensitive to varying qualities of care. Weinstein (1976) describes SAVE, which is an example of an instrument of this type which was developed from QualPacs. The instrument was eventually reduced to 9 items divided across three dimensions of care (physical, psychosocial and professional communication).

Given the range of theoretical and methodological frameworks available to assess quality and the discrepancies between scores obtained on using different instruments for observing the same phenomena, it is surprising that the assumption that care can be definitively measured is rarely challenged in the literature. Alternative approaches using qualitative methods for the study of quality of care are discussed further in section 2.1.3 below.

As discussed in section 2.1.1, the introduction of the nursing process is assumed to improve quality of patient care. However, there are few British empirical studies to support this assumption. Two studies of interest to a review of the quality of care literature are described below.

The first was undertaken by Metcalfe (1983) in a maternity hospital. The research problem was concerned with the effects of a change from task to patient allocation as a method of organising the delivery of care. Outcomes of the change were examined in terms of patient satisfaction, job satisfaction for nurses and midwives and the nature of the patient-nurse relationship. Observational, interview and questionnaire data were obtained prior to and following the changeover from task to patient allocation.

The results were equivocal in that although nurses and midwives liked the system of patient allocation it had little effect on patient satisfaction. The study also highlighted the interdependence between ward nurses, midwives and other hospital personnel in affecting the

delivery of care.

A more recent study was undertaken by Miller (1984,1985b) on six wards caring for the elderly. The aim of the study was to assess the benefits of the nursing process compared to task allocation on patient outcomes measured on the Clifton Assessment Procedures for the Elderly (CAPE) scale. Patients were also rated by nurses in terms of continence, physical dependence, mood and communication. Findings suggested that there was little difference in outcomes for short stay patients irrespective of the type of ward organisation. However, patients hospitalised for more than a month were more likely to be continent, less physically dependent and happier on nursing process rather than on task allocation wards.

These studies suggest that the nursing process offers a method for improving rather than a measure of assessing the quality of nursing (unless used for nursing audit as suggested by Phaneuf 1976). Miller (1985b), however, demonstrated that the effects of improvement following the introduction of the nursing process may be assessed by using outcome measures relevant to the setting.

2.1.3 Qualitative approaches to quality issues in the study of institutions

The difficulties of operationalising 'quality of nursing' into 'objective' measuring instruments and the translation of complex nurse-patient interactions into items and scores were highlighted in section 2.1.2. Evers (1982) summarises these difficulties in the following statement:

A quest for the holy grail of a definition and a measure of quality of care has proved elusive and many argue that as a relative concept the 'essence' of quality is not open to encapsulation in objective measures. (p.26)

For this reason Evers, like Baker (1978), adopted qualitative methods for the study of nursing. Both studies go some way to explore the multi-factorial nature of care in the geriatric ward setting, and the

difficulties of defining so-called 'objective' criteria for assessing quality. For example, Baker (1983), using participant observation to study nurses' perceptions of their role in the care of the hospitalised elderly, found that 'routine geriatric care' was predominant. She also described two divergent styles of geriatric nursing on the same ward. The style employed by the more recently arrived sister was patient centred and individualised and corresponded with the aspirations of nurse leaders. The alternative style employed by the rest of the nurses on the ward, and supported by doctors and nursing officers, was task-orientated and routinised. Baker concluded that nurse leaders took insufficient account of the wider issues which influenced quality of care, such as lack of feedback and mobility of ward staff and the lack of medical and senior nursing staff support for a more patient-centred approach to care.

Evers (1981a, 1985), in a later study, used case studies to describe patterns of work organisation to be found in longstay geriatric wards, and to derive some generalisations concerning their relationship and specified work outcomes, such as patients' physical and psychological wellbeing and use of resources.

In addition, a number of other studies (Coser 1963, Wing and Brown 1970, King et al 1971) are selected for review because of their contribution to an understanding of the quality of nursing in a wider organisational context. The studies extend beyond the literature reviewed in sections 2.1.1 and 2.1.2, by offering additional theoretical and methodological insights into quality issues. Not only do they offer complementary approaches to conceptualising quality but also further explanations for methods of work organisation and nurse-patient interaction, identified in section 2.1.1. Thus, further insights are gained as to: why patients are treated as work objects and nurses routinise their work; why cure rather than care work is

prioritised by nurses; the significance of interprofessional relationships between doctors and nurses; the effects of specific aspects of work organisation on patient outcomes.

The studies were undertaken in institutions for the recipients of the 'cinderella' services, namely the chronically sick (Coser 1963), the mentally ill (Wing and Brown 1970), the physically and mentally handicapped (King et al 1971) and the elderly (Baker 1978, 1983, Evers 1981a, 1985). It is in such institutions that issues of relevance to all nursing settings, such as the care-cure debate, interprofessional relationships, work organisation and nurse-patient interactions, are sharpened.

The studies are reviewed in order to complement the literature cited in sections 2.1.1 and 2.1.2. The investigators all employed multimethod research techniques including observation, interviews and carefully developed questionnaires and rating scales.

In her study, Coser (1963) uses Merton's (1957) notions of 'ritualism' and 'retreatism' to explain why and how nurses adapt to caring for the chronically sick rather than pursuing the culturally valued goal of curing them. Coser states that:

... the explicit goal of medical treatment is that of partial or complete recovery of the patient. This tends to be the most valued goal in an achievement-orientated society. (p.232)

Brown (1973), commenting on the mental hospital as an institution, considers that such social values may ultimately determine what the medical profession find interesting and as such affect 'the quality of care without special organisational values to combat them'.

Thus hospitals that 'only' care for patients and the staff who work in them hold little status in such a culturally orientated society. Staff consequently adapt by engaging in ritualistic behaviour (compulsive engagement in institutional norms) or retreatist behaviour (withdrawal from active involvement in goals or means).

Coser was able to confirm these theoretical propositions through empirical work in the Sunnydale hospital for the chronically sick and a Rehabilitation Center which aimed to return patients home. In Sunnydale, nurses were the principal care givers and patients were rarely attended by doctors. Nursing work was described in terms of physical aspects of the labour, and nurse-patient interaction was much lower than in the Center. Sunnydale nurses were said to feel unfulfilled by and alienated from their work which they experienced as 'task-orientated routine'. Patients were seen as 'vegetables' because of their physical and mental handicaps and by inference not worth the effort of more than minimum interaction. As was noted in section 2.1.1, Kelly and May (1982) reached similar conclusions about the sorts of patients who were regarded as 'good' or 'bad' according to diagnosis and treatment required.

Coser also reported that nurses withdrew frequently to support each other over a cup of coffee or a cigarette in the office. This phenomenon is of interest in the light of Smith's (1986) findings in a geriatric hospital that even when staff numbers increased the amount of staff-patient interaction did not. Similar findings were reported by Rhys-Hearn and Howard (1980) in a study of staffing levels in geriatric wards. 'Ideal' staffing levels did not necessarily mean that patients received 'ideal' care.

In relation to the patient-nurse dependency studies reviewed above, it was observed that the time spent by nurses on personal activities was not accounted for in the calculation of workload and staffing levels. Coser's study is a clear example of a strategy adopted by nurses to cope with the physical and emotional demands of certain types of work through the periodic withdrawal of labour.

Coser also noted the isolation of Sunnydale nurses from other professional groups, particularly doctors. She concluded that

interprofessional contact was vital in order that nurses developed a sense of themselves and their work as 'social actors'.

Similarly Brown (1973), drawing on research undertaken by himself and Wing (1970), describes the tendency of nurses who work in longstay hospitals for the chronically sick to develop or accept beliefs that dehumanise patients in order to protect themselves and allow them to get on with the work. Brown suggests that two separate sets of values develop, as illustrated by the nurse who cried during interview whilst reflecting on the ward she had been running in a mental hospital. She said she had sensed that patients sitting round doing nothing was not an inevitable consequence of the system. But as with Baker's (1983) nurses no one had given any feedback to say whether what was being done was right or wrong. Brown concludes:

Deeply felt humanitarian views which are present in most hospital workers will need strong social support to become generally effective. (p.414)

As suggested by Coser (1963) and discussed by Evers (1981a) below, the doctor may be an important source of support to nurses caring for the chronically sick and elderly.

The research by Wing and Brown (1970), referred to above, investigated the adverse effects on schizophrenic patients of long term hospitalisation. The researchers were particularly interested in the social environment and its effects on individual patients. They developed instruments to measure different aspects of the social environment. These aspects included itemisation of personal possessions; and the time budget, which related to all activities undertaken by the patient during the day and the time spent on different activities, including doing nothing. Another important measure of the social environment was concerned with ward restrictiveness in terms of rules and routines and whether they were applied indiscriminately or with discretion to individual patients.

Such an example was the indiscriminate washing of patients' hair during the weekly bath. Contact with the outside world was also recorded, such as visits to and by family and friends.

The different aspects of the social environment when put together were said to form a 'milieu of "social poverty" '. It was hypothesised and later confirmed that the greater the degree of social poverty to which the patient was subject the worse his/her degree of schizophrenia. The patient's clinical condition was measured on a scale of 'clinical poverty'. Attitudes towards discharge from hospital and their relationship to poverty of the milieu and length of stay were also noted.

The study took place in three hospitals, selected because of differences in social conditions and administrative policies. However, the critical factor in all three hospitals which appeared to bring about clinical handicap was the amount of time individual patients spent doing nothing; but also the degree of ward restrictiveness. Thus, work organisation that emphasised the indiscriminate application of rules and routine on individual patients was associated with more pessimistic outcomes.

King et al (1971) studied institutions for the care of handicapped children. During extensive fieldwork they developed a child management scale to measure the patterns of care to be found in different institutions. At one end of the scale were those institutions that demonstrated inflexible management practices towards individuals and situations. At the other end of the scale were those institutions that were flexible and child centred. It was assumed that child-centredness would result in 'better' child care.

In looking at a range of organisational variables in association with institutional or child orientation it appeared that the presence of staff who had received training in child care (rather than nurse

training) were more likely to be found in child-centred institutions. The findings from both these studies are consonant with Miller's (1985b) recent work on the nursing process which showed more favourable outcomes for longstay patients on wards which emphasised individualised rather than task orientated care. However, the King et al study also raises the significance of appropriate training to implementing patient/child orientated practice.

The final study to be considered is research undertaken by Evers into the care of the elderly (1981a). Evers' study is discussed elsewhere in this thesis (sections 2.1.1 and 2.1.2 in this chapter, and chapter 3). Those aspects of her study which specifically address quality issues are elaborated here. Evers' findings confirm the picture presented by Coser, Wing and Brown and King and colleagues above, and studies undertaken to look specifically at geriatric nursing care (Baker 1978, 1983, Wells 1980). Evers characterises the findings of these studies in the following way: routinised physical care; harassed nurses battling against the clock; depersonalisation of patients to the status of work objects.

Evers' contribution to the field is to provide a deeper understanding of patterns of work organisation described as two variations on Miller and Gwynne's (1972) notion of 'warehousing'; the importance of gender in terms of how patients experience hospitalisation and how their care is managed; and definitions of care outcomes as crude indices of physical and psychological wellbeing or 'illbeing'. Evers also described individual patient careers 'through time, space and social interaction through the hospital system' (p.55).

Although Evers largely concentrated on longstay wards she was able to characterise patient care goals into four distinct types: a) short-term care, rapid cure and discharge; (b) medium-term care,

rehabilitation and eventual discharge; (c) a 'good' death; (d) long-term care. Through a series of case studies, describing patient career patterns, Evers illustrated the differences in care among the different types of patients. Patients in group (a) neatly fitted into the medical model of care and were actively encouraged to participate in their care. At the other extreme, patients in group (d) were subject to either 'minimal' or 'personalised' warehousing.

Evers noted differences in the patterns of work organisation on the two types of wards even though patients' careers were shaped by the nursing routine. On 'minimal' warehousing wards patients were subject to indiscriminate routines and institutional clothing. On 'personalised' warehousing wards they were 'lovingly' cared for and had their own clothing, hairstyles, hearing aids, spectacles and dentures. Although nurses were the principal care givers in both types of ward, patients were regularly seen by doctors on 'personalised' wards but rarely where they were 'minimally' warehoused.

The critical factor appeared to be that on personalised wards sisters practised an individualised approach to patient management, whereas minimal warehousing was governed by tasks and routines. Incidents of inhumane treatment* were less likely on personalised wards.

In terms of gender, Evers' (1981b) findings have already been described in section 2.1.1 in relation to women's work and the appropriateness of mothering as a model for care. However, she also found that nurses tended to stereotype patients according to their

* Evers defined inhumane treatment as primary, e.g. ignoring patients' requests for relief of sleeplessness or coughs, or talking over patients; secondary: failure to respond to patients' distress, e.g. worry about future, grieving over a bereavement; tertiary: discussions about the patient when not present, e.g. deciding to apply for residential accommodation).

'childlike' characteristics. They were better able to care for physically and mentally dependent patients than those who were mentally alert and often critical of the nurses. Evers observed that such patients were often ignored, threatened and occasionally punished.

Evers' study of work organisation on geriatric wards has added to an understanding of the complexity of quality issues in nursing in general and geriatric care in particular. Of relevance to the present study was the finding that nurses had limited repertoires of practice which might result in inhumane treatment for patients if they did not fit in with those repertoires. The reasons for nurses' limited repertoires might be found in the lack of support given to them to look critically at their practice but also the undervaluing of geriatric nursing as women's work.

2.2 The Ward Learning Environment

The extensive literature available on the ward learning environment is reviewed under the following subsections: (2.2.1) the nature of student nurse teaching and learning; and (2.2.2) the structure of the ward learning environment.

In the subsection on the nature of student nurse teaching and learning, literature is reviewed which addresses general issues concerning the history and development of nurse training in Britain. As stated in the introduction to this chapter, a substantial British based research literature exists. This literature includes extensive reviews and findings based on empirical work. The main issues addressed by the literature pertain to the creation of the ward learning environment; the interface between teaching received in the school of nursing and practice on the ward; and the examination of teaching methods and learning processes appropriate to nurse training. The studies embrace a range of theoretical and methodological frameworks derived from education, psychology and, to a lesser extent, sociology. Nurse

training has been a popular research area for nurse teachers.

The second subsection on the structure of the ward learning environment describes the provision of adequate ward resources (human and material) as recommended by Donabedian (1966) (see section 2.1.2). Issues of staffing levels, skill mix, patterns of ward allocation according to patient characteristics, and associated stress, are considered in relation to the provision of adequate resources and optimum conditions for ward learning to take place.

2.2.1 The nature of student nurse teaching and learning

Extensive literature reviews and empirical work covering the many issues associated with nurse training have been undertaken over the last twenty years. However, as Orton (1981) points out, it is only in the last decade that the ward as a learning environment has received specific attention.

Government reports and enquiries over the years have increasingly expressed concern with deficiencies in nurse training. Many of these concerns have since become the foci of empirical work, such as recruitment and wastage (MacGuire 1964); the 'ideal' and 'real' of school and ward, 'theory' and 'practice' (Dodd 1973, Bendall 1975, Gallego 1983, Gott 1984); and the role of the ward sister in teaching and learning (Orton 1981, Ogier 1982, Fretwell 1982). The contents of these studies are discussed later.

Reviews of the historical literature relevant to nurse training have been undertaken by Fretwell (1982) and Alexander (1983). The work of an English surgeon (Balme 1937) and a nurse (Carter 1939) represent early examples of public statements on the shortcomings of nurse training which are still relevant in the 1980s. These shortcomings included the lack of integration between 'theory' and 'practice'; inadequate supervision and the use of trainee nurses 'as a piece of ward machinery to carry out certain duties which have got to be done' rather than as a

'student to learn' (Balme 1937, p.17).

These shortcomings, especially the lack of supervision and ward teaching on the part of ward sisters, were the subjects for further concern by a number of working parties, committees and studies during the next four decades (Lancet 1932, Ministry of Health 1943, 1947, Goddard 1953, MacGuire 1964).

The historical reasons for the constancy of the problems and their failure to be resolved are discussed by Davies (1980a, 1980b). Looking to nursing's origins (discussed above in section 2.1.1), she considers that nineteenth century British nursing leaders made a fatal compromise by organising training 'on the job' without a clear body of knowledge or defined teaching and learning roles. The establishment of the GNC in 1919 served to strengthen that compromise in Davies' view by formalising the precedent of using trainee nurses as cheap labour. Consequently, for the remainder of the twentieth century until the present, a reorganisation of nurse training which required alternatives to using trainee nurses as the labour force did not take place. Central government largely ignored the recommendations of the various committees, working parties and studies because of the huge financial commitment required to bring about these changes (MacGuire 1980).

The more recent past saw the publication of three influential reports (DHSS 1972, Commission on Nursing Education 1985, UKCC 1986). The reports identified many of the problems referred to over the previous four decades but also offered strategies for tackling them. For example, the UKCC proposed a two year core course, followed by an additional year of specialisation and a clinical career structure to retain qualified nurses. The proposal offered possibilities for putting an end to using students as the main work force and giving priority to educational rather than service needs.

Furthermore, the above discussion raises the question posed by

Alexander (1983) as to whether nurses are trained or educated. Alexander defines training as an apprenticeship style, skill orientated programme of instruction whereas education emphasises individual student development. It would appear from Alexander's review that the teaching and learning of nursing contains elements more akin to training than education. It is of interest that within nursing itself there has been a change in terminology. In 1977 the GNC was still issuing a 'training syllabus' but more recently the UKCC was using both terms in a report of one of its working groups (UKCC 1982). The RCN's report chaired by Judge was unambiguous in its title 'The Education of Nurses: A New Dispensation' (Commission on Nursing Education 1985). In its project paper 6, the UKCC's educational policy advisory committee makes a clear commitment to education rather than training as illustrated by the following statement:

... educationalists in other fields ... argue that what we must do is not to try to teach people all they need to know, but to teach them how to learn and how to analyse, to give them the confidence and the motivation and the facilities to develop themselves in relation to a changing environment. (UKCC 1985, p.21)

It is too early to assess the impact of the change in policy on the nature of student nurse teaching and learning. However, Clark (1986) is optimistic that the UKCC's legal responsibility for establishing and improving standards of nurse training and practice gives it the power as a statutory body to implement its own recommendations.

Teaching and learning theories are reviewed by Alexander (1983), Sheahan (1983) and Gott (1984) in order to look at teaching methods and learning processes within nursing. These theories originate from two opposing ideologies within psychology, namely the behaviourists and the cognitive field theorists (see Gott 1982, Alexander 1983 for fuller discussion). According to Entwistle and Hounsell (1975), the theories and their associated teaching methods may be placed on a continuum. The continuum ranges from a traditional view of learning as requiring

teacher control and the use of learning objectives on which to assess the acquisition of skills, to the more open exploratory approach which emphasises individual student development. As stated above, the latter approach is now being promoted by the UKCC.

Thus, the traditionalists see formal teaching activities as a prerequisite to ensure that learning is taking place whereas the exploratory approach incorporates Sheahan's (1983) suggestion that the teaching-learning process should integrate intuitive insights with systematic knowledge. Sheahan justifies his argument on the proposition that learning takes place informally from people other than 'official' teachers such as parents, friends and colleagues.

Similarly, Fretwell (1982) points out that 'teaching by example' is the basis of student nurse learning on the ward. However, Fretwell has found little evidence to support this assumption. In her view, learning conditions on the ward must be created in two ways: firstly by planning work to take account of students' needs and secondly by making trained staff and students aware that the work holds learning potential.

It would appear therefore that, in terms of learning theories and their associated methods, the preparation of student nurses more closely approximates to a training than an education. The distinction between nurse training and nurse education is also reflected in the different perceptions of nursing. These perceptions were discussed above in section 2.1.1. Evidence suggests that the acquisition of technical expertise and the completion of tasks is more highly valued by nurses than a patient-centred, problem solving approach to care. Consequently, it would appear that if nursing is perceived as technical and task orientated rather than patient-centred, then training rather than education might appear more appropriate. However, the choice of approach would depend on how the activity of nursing is perceived by teachers and students. Hockey (1980), for example, saw the need for

nurse teachers to educate for care. In addition to the acquisition of manual skills, her definition of what that education involved included the teaching of empathy, respect, the integration of theory and practice, and decision making.

Gott's (1984) study of the student nurse introductory course in three schools of nursing shows little evidence that teachers were following Hockey's recommendations. Through a process of observation and interviews in school and ward, Gott discovered that nurse teachers appeared to favour a traditional approach to teaching methods. The majority of them used formal lectures to teach technically orientated tasks. The teaching of interpersonal skills was neither a stated goal nor included on the timetable. The teachers did not adapt the content of their lectures to ward practice and, according to Gott, frequently emphasised that the 'school way' was correct. Thus, the students were exposed to conflicts between school and ward but not prepared by their teachers to handle them.

Godwin's (1983) examination of principles which underpin the training of rural health workers in Kenya is of relevance here. He draws attention to the importance of making a distinction between 'training for procedural task-orientated learning and training for higher order problem-solving skills'. Training to work in rural areas has emphasised the acquisition of technical skills in order to deliver a high quality of health care without taking into account the practical realities of limited resources and the need for health workers to adapt to such conditions.

Thus, Godwin proposes that it is essential to redress the balance between the two approaches by shifting the emphasis towards the acquisition of problem-solving skills. In order to do this, Godwin suggests that it is essential for programme planners to take into account the different ways in which people learn and the

characteristics of a good teacher. He promotes the need to set up learning objectives that relate to practice and the adoption of a variety of teaching methods. He suggests that these methods should include open relationships between students and teachers and the use of two-way discussion. In other words teachers should value and use the students' experiences of the 'real world' of practice.

The need to value and use the students' experience in the learning process is of particular importance in the context of student nurse training in Britain. During a three year apprenticeship style programme, students spend the majority of their time in the ward rather than the school. It is here, as Fretwell (1982) has pointed out, that the major part of their learning is assumed to take place as a result of sisters and trained staff who teach and students who learn as they work. Gott (1982) discovered for example that, even during their introductory nursing course, students assumed the values of the ward staff rather than their teachers. Dodd (1973) in an earlier study of nurse training found that students consistently regarded the ward and not the school and their teachers as important to their learning.

The consequences of this gap between 'theory' learnt in the school and ward 'practice' is demonstrated in the findings of a study undertaken by Bendall (1975). During her observation of learners working in the wards and their written accounts of how they cared for patients, Bendall found that the amount of agreement between the two versions was only about 20 per cent. On the basis of these findings Bendall recommended the urgent need for nurse teachers to teach on the wards rather than the classroom.

The processes of ward teaching and learning and the creation of the ward learning environment have been studied in some detail during the seventies. However there is little evidence to suggest that the gap between 'theory' and 'practice', school and ward has been reduced, nor

that nurse tutors have changed their location.

However, as a result of the studies, insights have been gained into how the ward learning environment is created.

Some of the studies will be reviewed in this subsection and others in subsection 2.2.2. The reason for the allocation of the studies to different subsections is that some of them are concerned with the creation of the ward as a learning environment in terms of teaching and learning processes; others with the structural conditions required for learning to take place. In some cases, the studies overlap with both sections.

Research findings suggest that not all wards have the same potential as a learning environment for student nurses (Orton 1981, Fretwell 1982, Lewin and Leach 1982, Ogier 1982). The critical variables include ward specialty (discussed in section 2.2.2) and the working relationships between permanent and trainee staff. Fretwell for example considers that how students and others perceive 'their transient worker role ... and the extent to which the role is prescribed or negotiated are crucial factors in understanding nurse education on the ward' (p.17).

Fretwell found for example that one of the factors which contributed to the creation of a favourable learning environment was whether the sister viewed the student as a 'learner' rather than a 'worker' and made 'a conscious effort to make teaching a reality'. Whether the sister created a positive learning environment or not, learners were observed to learn from each other on all wards but to a lesser extent in more highly rated wards. The teaching of 'theory' was also a reason for wards to be regarded as 'good' for learning. The sister was described as having an 'active' teaching role in such wards. Fretwell arrived at her conclusions through the distribution of questionnaires on the ward learning environment to learners and trained staff. She

also interviewed ward sisters and learners and observed teaching and learning activities on six wards chosen on the basis of questionnaire ratings.

The ward sister is seen by other researchers as having a crucial role to play in contributing to a favourable environment. Ogier (1982) identified different ward sister leadership styles and their relationship to learners' perception of favourable ward climates, based on findings from a series of questionnaires. The questionnaires were given to learners, on the ward climate; and to trained nurses, on leadership and personal biographies; and six sisters were audio recorded during one week of duty in six hospitals.

The leadership questionnaires produced two scores which were said to indicate 'consideration' and 'structure' of the ward sister in relation to 'subordinates'. High consideration scores were indicative of a sister who communicated warmly and well with others and considered their feelings. A high structure score was indicative of a sister who was purposeful and directive in her activities, receptive to new ideas and interested in giving information to others. Learners' ratings on the ward climate showed that they preferred sisters who achieved high consideration scores but only moderate structure scores. The reason for this in Ogier's view was that sisters with moderate scores were sufficiently structured to direct activities but not so much as to limit learning.

The audio recordings also supported the questionnaire scores by suggesting that 'ideal' sisters only spent half their duty time talking to other people but that half of that time was spent working with learners.

At the same time that Fretwell's and Ogier's studies were underway, Orton (1981) was undertaking research into ward learning and was developing a definition of its 'climate'. The findings of all three

studies supported each other, despite the use of different data collecting techniques.

Orton (1981) concluded from a review of the nursing literature (up to 1979) that nurses believed that the phenomenon of 'ward atmosphere' existed. However, few attempts appeared to have been made to conceptualise 'ward atmosphere' or 'climate'; nor to explore its relationship with the wellbeing of hospital staff and patients. Revans' (1964) work is a notable exception.

Orton claims that her own research was influenced by Revans' study of a number of hospitals in which he found that some of them had lower rates of staff turnover and sickness. These hospitals tended to have a good communication network and favourable ward atmospheres. One important indicator of a good ward atmosphere measured on a ward sister questionnaire was her positive attitude towards learners. Revans' study is discussed in more detail in section 2.3.

In addition to the nursing and associated literature, Orton also drew on notions of 'climate' from organisational psychology. The climate of an organisation was described as many faceted. Facets included those related to leadership style of superiors and the quality of their relationships with 'subordinates'. The role of 'consensus' in arriving at a definition of climate was seen by some authors as essential to its validation.

Orton developed a Likert scale questionnaire based on preliminary interviews with a variety of nursing personnel. The questionnaires were designed to answer questions about ward climates in different wards; the role of the ward sister; relationship of student satisfaction to ward experience; and agreement among students of their perceptions of wards. Some open-ended questions were also included.

The questionnaires were distributed to 325 students, 44 sisters and 27 nurse teachers across 44 different wards. Additional data were

obtained, based on the 44 ward sisters' self-reports.

On the basis of her findings, Orton concluded that students recognised 'ward climate' as a phenomenon and that it could be measured. Wards at extreme ends of the spectrum emerged from 'good' to 'poor'. Favourable climates were those where sisters had a high student orientation indicated by their ability to recognise their needs and a commitment to teaching. Like Fretwell (1982) Orton also found that wards with favourable climates recognised students as learners rather than workers. These wards also had a high level of teamwork and consultation between sisters and staff. The physical and emotional needs of both students and patients appeared to be met. The opposite was true of the low scoring wards. The relevance of Orton's findings to an understanding of good ward learning climates to patient care is discussed in section 2.3.

Orton compared her findings to those obtained by Revans from his ward sister questionnaire. It appeared that in the intervening years sisters' attitudes had shifted to being less doctor orientated and more open and interested in student nurses and their needs.

However, as Fretwell (1982) discovered during observation on six wards, individual sisters differed in their leadership styles, indicated by the way in which they gave work orders and communicated with junior staff. The leadership styles were described as 'autocratic', 'democratic' and 'laissez-faire'. Students rated wards more highly as a learning environment where the sister was democratic. Leadership styles were also complemented by sister's orientation towards doctors, patients or administrative duties.

Fretwell concluded that with the exception of one ward with high workload and patient turnover her observational data suggested that 'the way sister spent her time was a product of her own preferences and priorities'. Overall teaching students was seen to be very low on her

list of priorities.

Towell (1975) and Melia (1984) look at the wider implications of nurse training, namely at the socialisation process. Melia uses Merton's (1957) definition of socialisation as:

... the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge - in short the culture - current in the group of which they are, or seek to become a member.

Thus socialisation takes place primarily through interaction with 'significant' others.

This definition is also consonant with the aim of Towell's (1975) study in which he sought to discover the nature of the nursing staff sub-culture on three different types of ward in a psychiatric hospital. The participant observation methods and the underlying theoretical framework employed by Towell and Melia are discussed in some detail in chapter 3.

Towell described the subculture on different wards by noting terms used by nurses to categorise patients and the ways in which they interpreted patient behaviour and their effects on nurse-patient interaction. Towell also recorded the social organisation of the staff and medical treatment ideologies on each ward. It appeared that the predominant medical ideology was a critical factor in shaping nurses' perceptions of and interactions with patients. In terms of nurse training the social organisation of the ward meant that students were treated as junior employees rather than as trainees. Consequently, Towell described nurse training as a process of 'role learning' as students moved through different wards. Hence, roles and work expectations changed as students passed from one type of ward to another. Training was marked by 'discontinuity' in that practices learnt on one ward (or in the school of nursing) were not seen as appropriate in another.

Melia (1984) also found that student nurse training was marked by

discontinuity in that students, as they moved rapidly from ward to ward, were not guaranteed instruction from nurses who were either permanent or trained. Melia's findings led her to challenge the assumption that nursing is a true apprenticeship. She suggests that because of the way nursing is divided into the two major segments of education and service, and because of the way in which students spend three years moving rapidly from one segment to the other through a succession of wards, they do not undergo an apprenticeship but rather are socialised into compromise and conforming. Melia concludes that as long as nurse training is organised in this way, the sharp division between school and ward will continue. Consequently, nursing work on the ward will remain as a set of routinised tasks rather than being transformed to the problem-solving nursing process approach promoted by the school. Newly qualified staff are socialised to move on or conform to ward practice rather than implement the school's teaching.

On the evidence of research findings reviewed above, it appears that the nature of student nurse teaching and learning has not fundamentally changed during the last hundred years. However, research has provided important insights into the subjective needs of students and also into the conditions necessary for learning to take place. Research suggests that the provision of these conditions requires major organisational changes not only of social structures on the ward but also of the content and form of nurse training. The influence of the medical profession in shaping nurses' perceptions and work organisation is also apparent in some of the studies.

2.2.2 The structure of the ward learning environment

In section 2.2.1, the literature was reviewed which was concerned with the creation of the ward learning environment in terms of the processes of teaching and learning. In this section literature is reviewed which discusses structural conditions or resources required

for learning to take place. These conditions or resources include adequate staffing levels, skill mix, learning material as provided by patients and logical patterns of ward allocation.

The patient dependency studies were reviewed in section 2.1.2, where it was noted that they had been criticised for their static view of nursing and patient care. For example the staff-patient ratios recommended by a number of the studies do not take into account the training needs and experience of the nurses. Following the study of a number of hospitals, Moores and Thompson (1975) raised these issues, particularly in relation to the training of nurses. They make the point that allocation of learners should be organised in a way that makes learning sense for them, in relation to a number of characteristics. Amongst these characteristics will be: duration and number of allocations, staffing levels and mix, theoretical and teaching input to each allocation. Moores and Thompson developed a questionnaire based on these characteristics to find out what learners and ward sisters thought about the system of allocation operating in their hospitals. Moores (1979) suggested that the level of work load and the mix of trained to untrained staff might affect how and what the trainees were able to learn. Moores found great variability in staff numbers and mix amongst the wards and hospitals under study. One extreme example in one hospital ward resulted in the number of learners allocated there increasing in one week from three to 17. The ward specialty was paediatrics and the students tended to be allocated there in large numbers at specific stages of their training.

On the basis of his own and other researchers' findings (Revans 1964, Scott-Wright 1968, Cross, 1968), Moores concluded that the identification of the determinants of a positive learning environment was crucial. Although academically well qualified entrants to nursing were more likely to succeed in completing training, 'poor calibre

students have a higher probability of succeeding in good environments than do their better equipped counterparts in a poorer institution' (Moore 1979, p.72). In other words, the institutional characteristics which determined a good learning environment were of critical importance in determining whether students completed training or not. Moore hoped that his questionnaire could be used to identify whether the necessary determinants of good learning environments were present in institutions or not.

More recently, Reid and colleagues (1983) undertook an extensive study using a multimethod approach and a new statistical package for analysis of the data (logistic discriminant analysis). The aim of the research was to examine the criteria which determine the suitability of a clinical area for nurse training and to establish the optimum ratio of learners to trained staff to achieve adequate support.

Data collecting techniques included questionnaires distributed to students, trained ward staff, nurse managers and teachers. Non-participant observation took place on 13 medical wards over a 13 week period when three modules of students from each year of training were present. Activity sampling was undertaken in order to ascertain the amount of contact between trained staff and learners, and sisters' attitudes to education were recorded. The students were observed for the quantity and quality of the patient care activities they undertook. The observational items were based on the students' ward learning objectives.

Students were also 'tested' on their knowledge based on ward learning objectives before going to the wards and on return to the school. Patient dependency and turnover was also recorded.

The application of the new statistical technique, the logistic discriminant analysis, enabled the researchers to develop a formula for assessing a ward's stability as a clinical learning environment. They

also proposed a ward staffing ratio which would ensure an optimal staffing mix between trained staff and different grades of learners.

The researchers reported that a high percentage of the learning objectives were not practised on the wards and that all learners suffered a degree of disillusionment that peaked during the third year. The care of highly dependent patients was just as likely to be given by junior as by senior students. The students were also more likely to work with each other on most wards rather than with trained staff. Discriminant analysis confirmed that having satisfactory numbers of trained staff to learners was not critical in influencing the learning environment, but the amount of contact they had in caring for patients together was. Third year students were more involved in indirect patient care (for example administrative duties) and therefore identified the sister as more important to their learning. First and second year students identified staff nurses as more important to supporting their 'basic' and technical duties respectively. Reid's conclusion from the study reported in the Nursing Standard of 16 June 1983 was: Just by making best use of the existing staff and resources available teaching on wards can be significantly improved and in a much more consistent way.

Parkes (1980), using a questionnaire to measure psychological distress, a work satisfaction rating scale and short-term sickness/absence rates, studied the occupational stress of 101 female student nurses at two hospitals. Parkes was interested in association of stress and different types of wards and workloads. The subject of stress is an important factor to consider in the creation of favourable learning environments. In turn stress may not only affect learning but also the ability of the student to give adequate nursing care (see also Birch 1979, discussed below in section 2.3). Parkes' findings suggested that the students during their first six months of training experienced

higher levels of anxiety and depression and lower levels of work satisfaction on medical wards as opposed to surgical wards. These feelings were compounded if the students were allocated to a surgical ward first. Anxiety, but also work satisfaction, were both higher in male wards, although students reported high levels of work pressure and low levels of staff support in all wards. These results imply that the pattern and sequence of allocation may be critical to students in training and that their ability to learn and to give care is influenced to some extent by the gender of their patients and the specialty of the ward.

Roper (1975) undertook a series of studies of clinical areas to which students were allocated. She observed both students and patients and examined the nursing records in order to establish the learning content available on each ward. Roper discovered that sometimes patients' diagnostic labels were different from the designated specialty of the ward. It also appeared that any patient, irrespective of diagnosis, provided nurses with opportunities for unexpected teaching and learning. Overall, however, it was difficult to predict learning experience on the basis of medical specialty. Roper developed a patient profile instrument based on Henderson's (1960) activities of daily living and nursing activities generated from medical investigations and treatment. Roper suggested that this instrument could be used to define student learning and plan allocation related to patient dependency, based on the activities of daily living and other care associated with medical intervention. She also suggested that if learning objectives and patterns of allocation were planned on the basis of nursing care required by patients rather than of medical specialty, students could benefit from fewer allocations of longer duration. Over a decade later, student nurse learning material is still

defined according to medical specialty rather than nursing need. Part of the reason why this problem persists is related to the discussion in section 2.2.1 that students are placed to fulfil service rather than their learning needs. Furthermore, Towell (1975) and Fretwell (1982) found that medical ideology continues to shape nurses' expectations and interactions with patients.

2.3 The Relationship between Quality of Nursing and the Ward Learning Environment

A review of the literature on quality of nursing and the ward learning environment reveals many assumptions on the part of researchers that the two are related. Bendall (1975) and Orton (1981) are two such researchers. Bendall for example in her study of student nurse learning recommended the introduction of patient allocation so that nurses could be held accountable for their care. She considered that patient allocation would consolidate learning through focusing on patients rather than tasks. Bendall assumed that patient allocation, among other measures to improve training, would improve quality of care.

It is interesting that, a decade later, Ogier and Barnett (1985) found that sisters' leadership styles that were considered positive for students (high consideration; moderate structure) appeared to be in conflict with the styles necessary to implement the nursing process (high consideration; high structure). Similar measuring techniques were used as those used by Ogier (1982) in her original study.

Orton (1981) assumed that 'good' ward climates were beneficial for both students and patients. By inference, therefore, better learning climates should result in better patient care. Orton considered that climates affected patients' attitudes to getting better and their subsequent recovery rates. Like McGhee (1961) she concurred that the importance of the ward sister could not be overemphasised in relation to the patient (and student) who judges her on the atmosphere of her

ward. The work of Revans (1964) was also used by Orton to support the suggestion that staff attitudes and ward atmosphere or climate affect the quality of nursing and learning. However, these variables are less easy to measure in a quantifiable way than knowledge and skills.

Revans' research findings will be elaborated here for the insights they give into the relationship between quality of nursing and ward learning environments. Revans' thesis is as follows: hospitals are complex social organisations with distinct characteristics that affect the morale of staff and patients, either positively or negatively. Hospitals in which morale is high have lower turnover of all grades of nursing staff and their patients are discharged more quickly. Sickness and attrition rates among learners are lower. Wards in these hospitals are reported to have better atmospheres than those where turnover of staff is high and patients' average length of stay is longer. High morale is also associated with the effectiveness of the communication system within each hospital in reducing internal stresses and anxieties. Patients' recovery and nurse occupational stability, said Revans, are indicators of each group's ability to learn from what the hospital has to offer. He goes on to suggest that the patient and student nurse are often undergoing a similar learning process together: Both are faced with considerable tasks of adjustment, the student nurse in a way of life, the patient to the path of recovery. (p.54)

Revans made his assertions on the basis of extensive observation of hospitals and statistical analysis of staff and patient records.

Anxiety and stress were factors identified by Revans and others as having an affect on student learning and patient care. An investigation into the causes of wastage during training led Birch (1975) to speculate as to whether anxiety was an important influence on students' decision to withdraw. Further research (Birch 1979) confirmed his hypothesis that learners experienced unacceptable levels of

anxiety, particularly in relation to giving adequate psychological care to patients. The anxiety originated from both a lack of preparation by school staff to enable students to give adequate care to patients who were in pain and/or dying, and a lack of support from ward staff.

A final example of the relationship between quality of nursing and the ward as a learning environment is given from Alazewski's (1977) study of a hospital for the mentally handicapped. Alazewski suggested that the student nurse allocation system, by producing a high turnover of staff, created an 'unstable environment for both patients and nurses'. Alazewski concluded that this situation limited the development of ward teams, promoted rigid routinisation of care, and stifled learning opportunities. Alazewski's conclusions are in line with an earlier proposition put forward by Brown (1973) that:

... too great a turnover of staff ... makes it difficult to maintain stability of its belief system and personal knowledge of individual patients. (p.418)

Brown suggested that rate of staff turnover would affect the quality of the work. Indeed, Revans' findings appear to support this suggestion.

The literature reviewed above appears to suggest the association between quality of nursing and the ward as a learning environment. In the ward the creation of conditions that are favourable to patients also appear to create conditions for student learning. However, as demonstrated by Ogier and Barnett (1985) this may not always be the case. Conditions which militate against patient welfare, such as high turnover of staff, may also militate against student learning.

2.4 Summary of the Principal Issues in the Literature

From the extensive literature that exists on quality of nursing and the ward learning environment, the principal issues of relevance to the present study are summarised as follows.

Importance is attached to the implementation of the nursing process by nurse leaders and educators to improve quality of nursing and ward

learning (Bendall 1975, McFarlane 1976, 1977, GNC 1977). However, few empirical studies have been undertaken to assess how the nursing process has been implemented and its implications for quality of nursing and learning. The findings of these studies are inconclusive (De la Cuesta 1979, Metcalfe 1983, Miller 1985b, Keyser 1985). The status of the nursing process as a teaching device for systematising nursing knowledge and skills, and as a work method for individualising patient care, remain equivocal.

The content of nursing work has been described as comprising basic, technical and affective elements (Goddard 1953). The technical elements are most often identified by doctors, trained nurses and students as the 'real' work of patient care (Anderson 1973, Fretwell 1982, Melia 1982, Alexander 1983). The literature highlights the inadequacies of these definitions and distinctions and offers explanations for their existence (Strauss et al 1982b, Ungerson 1983b, Oakley 1984). The literature highlights the role of patients in influencing the quality of nursing they receive and the ward learning environment (Evers 1981b, Strauss et al 1982a, Kelly and May 1982). Their influence may be direct, in terms of how they react to the care being given to them, or indirect, by virtue of their medical, nursing and biographical characteristics. The use of medical specialties to organise nurse training was shown by Roper (1975) to be an unreliable way of predicting learning experiences available to students. Not only were patients' diagnostic labels often different from the designated specialty of the ward but patients, irrespective of diagnosis, provided nurses with unexpected opportunities for teaching and learning. Roper used patient profiles based on Henderson's (1960) activities of daily living and nursing activities associated with medical interventions to identify these opportunities. The need to plan student allocation based on nursing rather than medical criteria was pointed out by Moores and

Thompson (1975) and Parkes (1980) who found that the duration, pattern and sequencing of allocation was important. Although favourable staffing ratios between trained and learner nurses was also found to be important in terms of student learning (Moore 1979), the amount of contact between students and qualified staff in caring for patients together was also critical (Reid 1983).

The literature suggests that ward climates or atmospheres affect both quality of nursing and students' learning (Revans, 1964, Fretwell 1982, Orton 1981). Good communication and interpersonal relationships among sisters, trained staff, students and patients appear to be critical indicators of quality of nursing and learning.

The different approaches to the conceptualisation of quality of nursing were characterised in the literature as quantitative and qualitative. Quantitative approaches to the study of quality of nursing believed that nursing care could be 'objectively' measured (Wandelt and Ager 1974, Jelinek et al. 1974, Goldstone et al 1983). Evers (1982), who represented the qualitative approach to the study of quality, made the statement that the 'essence' of quality as a relative concept is not able to be encapsulated in 'objective' measures. Qualitative studies, many of which were undertaken in longstay institutions, looked at quality issues from the wider organisational context and incorporated the 'subjective' perspectives of participants (Towell 1975, Baker 1978, Melia 1982, Evers 1985).

The literature suggests that nurse leaders and educationalists emphasise the caring role of the nurse, the nursing process and the promotion of better communication and interpersonal skills between nurses and patients (Armstrong 1983). The emphasis contained in this version of nursing as opposed to the alternative view of nurses as the doctor's assistant, fails to take in to account the following issues: the emotional complexities of care work (Menzies 1960, Smith 1986) ;

its relationship to the gender division of labour within society in general and the health service in particular (Ungerson 1983a, Oakley 1984); and the power relationships between doctors (predominantly men) and nurses (predominantly female) (Friedson 1970, Oakley 1984).

In the present study, Hochschild's (1983) analysis of emotional labour in the work place is used as a conceptual means to understanding the emotional complexities of the nursing labour process and the training and supervision of students in school and ward. Hochschild claims that the quality of a service is judged by the emotional style in which it is given. The present study sought to address Hochschild's claim by considering the visibility of communication and encounter as the central work relationship in the way in which nurse teachers taught and ward sisters organised and prioritised patient care. Following Hochschild, it might be expected that the emotional style in which nurse teachers taught and sisters managed their wards, would have implications for the quality of nursing and learning outcomes for students. Emotional labour therefore, as a concept, appeared to offer theoretical possibilities for exploring through the data the nature of the relationship between quality of nursing and the ward learning environment for students in training.

CHAPTER 3

METHODOLOGY

As presented in chapter 1, the aim of the present study was to explore the nature of the relationship between quality of nursing and the ward as a learning environment for student nurses. In pursuit of this aim, ways of conceptualising the variables, quality of nursing and the ward as a learning environment were investigated in a variety of wards and from a number of nursing and patient perspectives.

The main focus of the study was the student nurse in the ward setting, as learner and principal giver of direct patient care.

3.1 Methodological Perspectives

This section describes the methodological perspectives which shaped the conceptualisation of the research problem and the development of a research strategy and techniques used to collect and analyse data in the present study.

In chapter 2, it was noted that the literature relevant to the research problem - quality of nursing and the ward as a learning environment - were two distinct and substantial research areas.

Research pertaining to both areas was reviewed and seen to embrace a variety of theoretical and methodological approaches from such disciplines as biology, psychology, and sociology. As discussed in chapter two, the studies represented a theoretical and methodological continuum, characterised by positivist 'objective' research approaches at one end, which have traditionally dominated nursing research, to interpretivist 'subjective' qualitative approaches at the other. The relative merits of the different approaches and their application to the study of nursing are critically and comprehensively discussed by Melia (1981). As she points out, both approaches have their place in research. But the appeal of qualitative sociological methods in the study of complex phenomena associated with nursing lies in their

flexibility for data handling, hypothesis formulation and exploration in which researchers and subjects (usually referred to as 'actors') have an active and interactive role. Commenting on her own qualitative approach to the study of student nurses' views of nursing, Melia states:

It is the researcher's job to produce an account of how the participants see the situation or phenomenon in question; the analysis then goes beyond this point when analytical concepts, which transcend the meanings of actors, are developed. (Melia 1982, p.329)

In addition to Melia's study, other studies reviewed in chapter 2 (Towell 1975, Baker 1978, Dingwall 1978, James 1984, Evers 1985) are indicative of the increasing recognition by researchers of the value of incorporating qualitative, sociological methods into research about nursing.

An approach common to all the studies was the use of 'participant observation' to collect data in a variety of 'natural' rather than experimental settings. As participant observation was a core method used in the present study, a discussion of its practical application in the field is presented below in section 3.2.2.

The classification of the participant observer role is well documented in the literature (Gold 1969, Denzin 1970, Pearsall 1970). The role is most consistently described as lying on a continuum from complete participant at one end to complete observer at the other. Collins (1984) points out that this continuum is not a simple matter of classification, but related to distinct theoretical approaches underpinning the definition of the role.

Thus, the complete participant role is theoretically inspired by qualitative, interpretivist research traditions whereas the complete observer role tends towards positivism and quantification common in the natural and medical sciences. Collins suggests that the idealisation of the participant's role in this way is impractical and might more

realistically be seen 'as a range of compromises' in the research setting.

He proposes an alternative classification in which he describes the complete observer role as 'unobtrusive observation' and the complete participant as 'participant comprehension'. He describes each category of observation in the following way.

Unobtrusive observation describes an approach in which the researcher does not inform the research subjects that they are being observed. In Collins' view, there are no guarantees that observer effect does not occur. Simply by being there the researcher may change the usual patterns of interaction amongst those being observed. On the other hand, a researcher may choose to inform his/her subjects that they are being observed but eventually s/he may blend into the research setting and cease to be obtrusive. This latter description was found to fit the experiences of the present researcher during non-participant observation on the wards and in the classroom.

Collins' research approach is that of participant comprehension in which the act of participating is central and essential to the method. The researcher enters the research setting seeking to maximise rather than minimise her interaction so as to grow both in competence and comprehension of the 'native culture'. The present researcher adopted this approach during participant observation on the wards.

The majority of these studies also adopted a grounded theory approach advocated by Glaser and Strauss (1967) for the gathering, handling and analysis of data in order to generate 'modes of conceptualisation for describing and explaining'. Glaser and Strauss emphasise that the aim of their research approach is to generate rather than to verify theory through 'theoretical sampling'. Theoretical sampling is described as the joint collection, coding and analysis of data whereby the researcher decides what further data to collect and

where to find them based on data already collected, coded and analysed. Thus, theory is seen as 'a process and ever developing entity' through the creation of conceptual categories and their properties and hypotheses or general relations among them.

The development of feminist research in recent years has made a significant contribution to both sociological and nursing research. In view of this development, feminist research is also considered here. Bell and Roberts (1984) draw attention to the emergence of a 'strong programme' of feminist sociology since the late seventies. Feminist sociology is concerned not only with raising gender issues in the formulation of research problems, methods and analysis but also takes account of the 'differences in the way that research is organised, carried out and written up as being based on the gender of the researcher' (Bell and Roberts 1984, p.3).

James (1984) describes how feminist sociology sensitised her to the importance of gender relations. Although not on the original agenda of her study of predominantly female 'professional' carers of dying people, she began to see the 'explanatory value' of gender relations for them to become 'a significant part of the analysis'.

Webb (1984b) has explicitly put feminist sociology on the nursing research agenda. Drawing on the writings of feminist sociologists she describes feminist research 'as critique' which:

... aims specifically to work towards defining alternatives and understanding everyday experience in order to bring about change. Analysis and critique of research methods leads on to analysis and critique in the research context through consciousness raising both for researcher and researched. (p.250)

Webb also sees feminist research as 'challenging of research protocols which have the effect of "denying the authenticity of women's experience as women"' (McCormack 1981). In a study of women undergoing hysterectomy Webb describes how by adopting a feminist methodology she:

... developed intimacy with the women and invested my subjectivity in the research and in return learned in great depth and richness about their feelings and experiences. (p.255)

The contribution of feminist perspectives to nursing research is particularly pertinent, given that it is a predominantly female occupation and nurses are involved in traditionally female roles and × work activities proscribed by the predominantly male medical profession (see Ungerson 1983b, reviewed in chapter 2).

Feminist research can be seen to value yet develop qualitative research traditions by making gender relations visible at the level of both researcher and researched. The integration of feminist perspectives in the present study as they related to participant observation in the field and during interview are described below in section 3.2.1(b).

As stated above, nursing research has traditionally been dominated by quantitative approaches. These quantitative traditions of the early years of nursing research were in Spencer's view 'mainly used ... possibly because the occupation of nursing is dominated by medical science, which generally uses the same methodological approach' (Spencer 1983). He also criticises these traditions for failing:

... to increase knowledge of the specific activity of nursing - helping people recover, since this involves interactions between at least two people, and must include the subjective part of each person taking part in the activity. (p.24)

This was indeed the question that Revans asked of his own 'quantitative' research findings (Revans 1964). For although it was inferred that in hospitals where staff morale was high patients were discharged more quickly, these findings failed to take account of patients' subjective experience of hospital. Thus, neither the benefit derived from hospitalisation nor their physical and emotional condition were known on discharge.

Cicourel's discussion on the fixed choice questionnaire is of

relevance here given its popularity as a quantitative instrument in social research (Cicourel 1964). Cicourel describes how such instruments allow the researcher to devise coding rules and scaling devices to 'transform the structure of social action into quantifiable elements' which 'obscure(s) how the researcher's implicit common-sense knowledge enters the decision making process identified as "scientific rules of procedure" while simultaneously transforming the actor's responses ...'. In other words, the questionnaire is not as 'objective' as it at first appears. Cicourel goes on to recommend that 'Operational definitions of sociological concepts need to be constructed in such a way in order that everyday life experience and conduct is reflected in them' (p.120).

Following Cicourel, Evers (1985) felt that in her own research the use of questionnaires and structured interviews would build in assumptions and abstractions which would obscure the subtle variations in perceptions and behaviour between staff and patients. She therefore used a variety of data collecting methods including non-participant observation, medical and nursing records and informal conversations and interviews with patients, medical and nursing staff.

Denzin (1970) adds a further dimension to the discussion by pointing out that the use of particular methods are not 'neutral' nor 'atheoretical' but 'represent lines of action towards the empirical world'. Thus 'surveys for example dictate a stance towards the invariant and stable features of the reality, while participant observation assumes a reality continually in change and flux'. Denzin advocates that in order to 'raise sociology above personalistic biases that stem from single methodologies' researchers should use 'triangulation, or a combination of methodologies in the study of the same phenomena'. Denzin's definition of each method implies a 'triangulated perspective' (p.300). He sees participant observation for

example as 'combining survey interviewing, document analysis, direct observation and observer participation' (p.308). This indeed was the strategy employed by Evers (1985) and the present researcher as outlined in more detail below.

Ultimately, however, the choice of particular methodologies and theoretical frameworks depend not only on the research problem under study but also on the researcher's particular stance, personal experience and ability to use what C. Wright Mills has called 'the sociological imagination' and 'intellectual craftsmanship' (Mills 1970). It is well to bear in mind that Mills, and indeed Glaser and Strauss and Denzin, were writing at a time that pre-dated the 'gender-neutral' language of feminist researchers. Indeed it is the traditionally 'masculine' language of sociology with which the feminists take issue.

The following extracts from Mills' classic work 'The Sociological Imagination' illustrate that the content rather than the style of writing is not in contradiction with feminist research in its promotion of qualitative approaches.

Mills defines sociological imagination as 'the quality of mind essential to grasp the interplay of man (sic) and society, of biography and history, of self and world'. He goes on to describe the sociological imagination as enabling 'its possessor to understand the larger historical scene in terms of its meaning for the external career of a variety of individuals' and to 'grasp history and biography and the relations between the two within society' (p.12).

Although the present study focuses on student nurses both as individuals and as a collective in the ward setting, the exercise of the sociological imagination sensitises the researcher to the interaction between individual and context and the macro issues of nursing in particular and health care in general.

In the appendix to 'The Sociological Imagination' Mills, in

introducing the notion of 'Intellectual Craftmanship' to 'the beginning student', urges 'that you must learn to use your life experience in your intellectual work continually to examine and interpret it.' Mills recommends that the way to do this is by keeping a journal which enables the researcher 'to control this rather elaborate interplay, to capture what you experience and sort it out; only in this way can you hope to guide and test your reflection' (p.216). The first part of Mills' extract on 'life experience' is of pertinence to the present researcher, since former experiences as a nurse and nurse teacher were inevitably brought to bear on the study and indeed set the original formulation of the research problem in motion. Similarly, as the feminist sociologists emphasise, the gender of the researcher is also part of the fundamental experience that shapes the research enterprise.

In terms of keeping a journal, the present researcher kept a field work diary not only to capture insights about the research but also to document other events external to the research that affected her reflectivity.

The above account described the methodological perspectives which shaped the conceptualisation of the research problem and the development and analysis of the strategy and techniques used to collect data in the present study. The account also demonstrates the interplay between methodology and strategy and the theoretical framework which underpins the use of specific techniques.

3.2 Research Strategy and Techniques used in the Present Study

3.2.1 Overview

Key research perspectives for the study included 'triangulation' or a multimethod research approach advocated by Denzin (1970) using both quantitative and qualitative techniques; and the application of strategies recommended by Glaser and Strauss (1967) for flexible data handling to generate theory from data (i.e. grounded theory).

Below follows a summary of the techniques used in the present study as defined by Denzin (1970).

Survey Interviewing: questionnaires with students from 12 medical wards (Fretwell, 1983); semistructured interviews with students, sisters (Pembrey 1980), tutors, patients (Coser 1962).

Document Analysis: student biographical data; patient data on bed occupancy, death and discharge.

Plan of student nurse training, timetables, prospectus and school progress reports.

Direct Observation: Barr Dependency Checklist (Barr 1967);

non-participant observation instrument:

QualPacs (Wandelt and Ager 1974);

non-participant observation of selected classes in the school of nursing.

Observer Participation: Case studies of four wards and interviews (Denzin 1970, Melia 1982, Collins 1984).

Data were analysed as the research progressed, using qualitative research strategies advocated by Glaser and Strauss (1967) irrespective of whether they were collected by quantitative or qualitative techniques. For clarity the techniques are categorised below under their appropriate headings. The decision to allocate them to either category (quantitative or qualitative) depended on the research traditions from which they originated.

3.2.2 Qualitative strategies

(a) Grounded theory

As stated above, the key research strategy adopted in the present study was that of grounded theory (Glaser and Strauss 1967). Data were formally collected and analysed in order to decide what data to collect and where to find them in future fieldwork. This process is described

as an integral part of the research procedure (section 3.3) and data analysis (section 3.4).

(b) Participant observation

The core research method was that of participant observation used during fieldwork on four medical wards, in the school of nursing and during interviews (Melia, 1982).

Towell (1975) and James (1984) offer insights into the participant observer role of which the present researcher was aware during the negotiation of her research role. Like Oakley (1981), they challenge the conventional assumption that subjects under study are passive. Towell and James describe the development of social relations in the research setting where the subjects clearly made choices about how they reacted and what they would say either during interview or in the field. James gives the example of arranging to tape-record an interview with a nurse from the unit she was studying. Even though both interviewer and interviewee knew each other from their encounters in the field the latter invited a friend to be interviewed with her, so introducing an element of control to the situation.

Indeed, feminist researchers highlight the vulnerability of research subjects especially during interview in which traditionally the researcher 'takes' all the information on offer without reciprocity or responsibility (Stanley and Wise 1983, Finch 1984). These observations are particularly relevant to the study of nursing since nurses are especially vulnerable to external authority structures. As Towell notes, the 'type of relationship' one builds and sustains 'with different members of the organisation' shapes 'the kinds of data to which these relationships are permitted access' (Towell 1975, p.36). Alternatively, as feminist researchers point out, the researcher has a responsibility to protect the vulnerability of persons under study. James for example periodically made outrageous statements to remind

people that there was a researcher in their midst (James 1984).

The negotiation of the research role in the present study is described in section 3.3, as part of the research procedure.

(c) Interviews

Melia's application of the participant observer role during interview was also adopted by the present researcher. Melia (1982) contends that 'the close involvement of the researcher in the production of the data is as true of the informal interview method of data production as it is of participant observation' (p.329). Not only was Melia familiar with the social setting from which her subjects originated but she used the interview as a forum through which to interact with them in the production of data. Following Glaser and Strauss (1967) she also handled the data from taped interviews as if it were fieldnotes from participant observation in order to guide future data collection and the generation of theory.

Similarly, in the present study, the content of the interviews was analysed for emergent themes around an agenda of questions in order to integrate them into future interviews.

Although Melia is not writing from an explicitly feminist perspective, her approach to interviewing which involves interaction between interviewer and interviewees is in some ways similar to that of Oakley's who is. Oakley (1981) offers an approach to interviewing that questions conventional 'male paradigms' which mystify 'the researcher and the researched as objective instruments of data production' and condemns 'personal involvement' as 'dangerous bias' (p.58). Both Oakley and Melia therefore see the use of subjectivity as essential to the interviewing process and production of data. In the present study a similar perspective was adopted both in the field and during interview.

Interview agendas, schedule and guide

Interviews were constructed around an agenda, schedule or guide of

topics/questions which were discussed with everyone according to group (i.e. student, tutor, sister, patient). Additional topics/questions also evolved during individual interviews, and were integrated into ongoing data collection. The agendas, schedule and guide are contained in appendices 2-5. A summary of the topics and questions contained in each, for each group being interviewed, is given below.

The student nurse interview agenda was organised around the following topics:

General overview of training; integration of classroom teaching and ward practice; teaching and learning: identification of key people and incidents; the wards: nature of the work and quality of nursing; formal training requirements; the role of the school of nursing.

A similar agenda was used during student discussion groups.

The nurse tutor interview agenda was organised around the following topics:

Background prior to and reasons for becoming a nurse teacher; the school-ward contact; theoretical content of training; student nurses' personal and learning needs; the role of the school of nursing.

The nursing process, patterns of ward allocation and the teaching and learning of interpersonal skills and communication were added to the schedule of topics for both students and teachers as the research progressed.

The ward sister interview schedule was based on Pembrey's (1980) semi-structured interview schedule. The schedule was organised around questions rather than topics and aimed at finding out about the ward sister's resources and how she organised nursing on 'a typical day', allocated the work, and received feedback on what had been done. These questions gave insights into the ward sister's interpretation of the nursing process and supervision of students. Additional topics were added for the purposes of the present study. These topics included:

student nurse teaching and learning; role of and contact with the school of nursing; nature of the work and the learning material on the ward (see appendix 4).

Coser's (1962) patient interview guide was used to explore patients' perceptions of quality of nursing (see appendix 5). Patients were asked to describe their 'ideal' doctor, nurse or patient; also their experience of hospitalisation from the point of view of resources and contact with personnel. Communication and interpersonal skills and the role of student nurses as care givers emerged as important topics for further discussion.

The decision to use an existing schedule/guide, with which to interview ward sisters and patients, was based on their relevance to the research problem under study. For example, Pembrey (1980) developed her schedule from exploratory work. She found it to be a 'useful instrument' which prompted ward sisters to talk about their perceptions of management and daily work priorities.

Coser's (1962) interview guide yielded data about the content of nursing work and patients' perceptions of hospitalisation. She found that patients with whom she was familiar were more likely to talk at length during interview than others with whom she was not.

The validity and reliability of the data obtained using qualitative strategies are an integral part of an approach such as grounded theory, which seeks to generate, rather than verify theory from the data. Thus, validity is implicit when data are simultaneously collected, handled and analysed to shape ongoing data collection and to develop and confirm working hypotheses. Similarly, reliability is ascertained during the participant observer role in that the researcher, over time and with increasing familiarity, is able to check the accuracy and recurrence of the data, in a number of settings and from a number of participants.

3.2.3 Quantitative techniques

In the spirit of triangulated methodological perspectives (Denzin 1970), techniques developed by other researchers for conceptualising the variables - quality of nursing and the ward as a learning environment - were incorporated into the present study. They were used as data sources complementary to those collected during interviews and field observations and to raise the findings above the 'personalistic biases' of the researcher (Denzin 1970).

(a) Pembrey's checklist of ward sisters' daily work priorities and problems

Pembrey's (1980) checklist of work priorities was originally designed to monitor the importance ward sisters attached to activities associated with the 'daily management cycle'. As was discussed in chapter 2, section 2.1.1, of this thesis, 'the management cycle' was shown to be conceptually linked to an understanding of sisters' ward management styles and use of the nursing process. In this study the checklist was used to provide indicators of sisters' management styles and use of the nursing process. In turn, these indicators provide insights into quality of nursing and the ward learning environment.

The checklist of work priorities includes: work with students; giving nursing care to patients; asking nurses to report on their work (see appendix 6).

Pembrey's checklist of work problems was also used in the study in order to identify some of the common problems experienced by ward sisters. The checklist includes: being unable to complete one job at a time; trained staff moving frequently; students allocated to the ward for too short a period (see appendix 7).

The responses to the checklists give insights into how a ward sister organises her day; handles information and feedback; prioritises her activities in relation to doctors, other nurses, students and patients;

and how much control she felt she was able to exercise over her own work environment.

Pembrey based the content of the checklists on exploratory observations and interviews, and carried out pilot work to establish the validity of the items used. She claimed that each item on the checklists demonstrated discriminant validity. Pembrey also controlled for bias by ranking the items in different orders on two different forms.

(b) The Quality Patient Care Scale (QualPacs)
(Wandelt and Ager 1974)

The theoretical and methodological complexities of conceptualising the quality of nursing are discussed in chapter 2, section 2.1.2. QualPacs, a quantitative measuring instrument, was selected for the present study because it was developed in an educational (Wayne State University Faculty of Nursing) rather than a service setting (Wandelt and Ager 1974). This seemed an appropriate choice given the particular research question under study. QualPacs also has a significant research literature attached to it and a group of British nurses have used it (Wainwright and Burnip 1983). Hence they were seen as a potential reference group to discuss its application and use in a British context. QualPacs sets out to measure the multidimensional concept of quality of care. It is patient centred in that groups of patients are selected from a unit and observed for a two hour period by qualified nurses trained to use the scale. Up to another two hours are spent collecting data from case notes, nursing records and patient charts or listening to nurse handover reports. The dimensions of nursing being observed relate to physical and psycho-social care of the patient, staff communication and professional implications covering 68 items (see appendix 9).

Examples of items under the different dimensions include:

Psychosocial Individual: 'Patient receives nurse's full attention'; 'Appropriate action is taken in response to anticipated or manifest patient anxiety or distress'; and 'Appropriate topics for conversation are chosen'.

Examples of items under the Physical dimension include: 'Patient's daily hygiene needs for cleanliness and acceptable appearance are met;' and 'Established techniques for safe administration of medications and parenteral fluids are carried out'.

Examples of items under the dimension of Professional Implications include: 'Changes in care and care plans reflect continuous evaluation of results of nursing care'; and 'Organisation and management of nursing activities reflect due consideration for patient needs'.

The items are accompanied by cues to help the raters allocate scores on a 5 point scale. The cues give guidance on the underlying concepts of quality for each item. The authors of the scale suggest the cues may be redesigned to fit the particular context in which nurses are working to agree on acceptable standards (Wandelt and Ager 1974, p.38). All nurse-patient interactions for the selected patients are observed and rated.

The standard of care expected is that of a first level (newly qualified) staff nurse described as 'safe, adequate, therapeutic and supportive' to the patient (p.45). The content and tone of each interaction is also considered. The authors suggest that observers may prefer a more concrete frame of reference than 'Best' (5 points) through to 'Poorest' care (1 point) on which to base their five point rating for each item. If this is the case, observers are recommended to think of staff nurses they have known who would correspond to each of the five categories of 'Best' (5), 'Between' (4), 'Average' (3), 'Between' (2) or 'Poorest' (1) care giver.

At the end of the observation period the care received by each

patient is awarded a mean score between 1 and 5 points. This score is the result of the sum of item means for each dimension, divided by the number of items rated against nursing care observed. The score reflects the overall quality of nursing received by patients rather than being a measure of individual nurse competency.

The authors recommend that nurses train to use the scale over two-days of try-outs and discussion based on the observation of up to five patients. Observers are asked to use their clinical judgements as trained nurses to rate their observations. A minimum of 30 items over four interactions are recommended as a baseline for providing a reliable score. Wandelt and Ager (1974) claim that raters consistently agree in their judgements of quality of care in different settings and on many occasions.

During pilot testing by Wandelt and Ager, high correlations were achieved between scores obtained by pairs of raters. An intraclass correlation of 0.74 for 96 patients, 0.91 for 6 patients, and 0.64 for 11 patients, were reported. Internal consistency on 55 items based on 20 patients' data was also found to be high, at 0.96 (Kuder-Richardson coefficient) in the first of the three studies reported above. Test-retest stability in one rater over a number of days was also obtained on scores for 5 patients at 0.98 (Pearson correlation). The types of correlation coefficients used were selected on the basis of the data being tested for reliability.

Tests of validity of the instrument were poor as reported by the authors in 1974. A more recent paper describes a study 'to clarify the subdimensions of the domain of quality nursing care as measured by QualPacs' (Fox and Ventura 1984). The findings suggest that the instrument 'appears to have a rather narrowly defined application of quality of care' and that 'there is a need for further validation of this instrument' (Fox and Ventura 1984, p.117).

The general issues of validity related to the measurement of quality of nursing were discussed in chapter 2, section 2.1.2. It was found, for example, that when combinations of process instruments (QualPacs, Rush-Medicus, Phaneuf Formula) were used in conjunction to measure quality of care received by the same patients, scores did not strongly correlate (Ventura 1980, Ventura et al 1982).

(c) Barr's checklist of patient dependency and staffing levels (Barr 1967)

The role of dependency studies in assessing the quality of nursing is discussed in chapter 2, section 2.1.2.

The Barr checklist of patient dependency according to functional and technical nursing procedures (see appendix 10) was used in order to assess whether patients belong to low, medium or high dependency categories. The Aberdeen nursing formula (Scottish Home and Health Department, 1969) allotted time taken to care for patients in each group, i.e. High Dependency - 8 hours of nursing time; Medium Dependency - 4 hours of nursing time; Low Dependency - 40 minutes of nursing time; each period out of 24 hours. The number of staff on each shift was recorded and the number of nursing hours available for the patient workload were compared. In this way it was possible to obtain a crude measure of staffing ratios and workload. Staffing mix (trained staff and students) was noted. The person in charge of the shift was also asked for his/her subjective impressions of the workload and staffing levels.

The Barr dependency checklist which divides patients into three care groups (high, medium, low) has been applied in several hospitals since its development in the 1960s. The categories were based on a number of time studies. Wilson-Barnett (1979), whilst describing the dependency categories as 'straight forward' states that their accuracy 'will depend on the reliability of the original time studies and the consistency with which the dependency forms are completed' (p.102).

The timings based on the Aberdeen formula (SHHD 1969) linked to the three categories, i.e. high dependency patients require 8 hours of nursing time in 24 hours; medium dependency patients require 4 hours of nursing time in 24 hours; low dependency patients require 40 minutes of nursing time in 24 hours, have been verified (Sutton 1979).

The limitations of dependency studies in measuring patient workload and staffing levels were discussed in chapter 2, section 2.1.2.

(d) Fretwell's rating questionnaire of the ward learning environment (Fretwell 1983, 1985)

Fretwell's questionnaire on the ward learning environment was given to students (Fretwell 1983,1985).

Thirty-six items were grouped in six sections, A, B, C, D, E and F. Each section looked at different characteristics of the ward learning environment (appendix 8). Its content was based on previous research undertaken by Fretwell (1976, 1982) and Orton (1981). Section A contained seven items which asked respondents to rate the ward learning environment in terms of workload, staffing levels and mix (items 4, 6 and 7). Items 1, 3 and 5 rated the respondent's perception of potential and actual learning on the ward. Item 2 rated the extent to which students felt happy with their ward experience. As such it could be seen as an indicator of their general feeling of wellbeing whilst on the ward.

Section B rated 'Ward Atmosphere/Staff Relations' on seven items. These items asked students to respond to statements such as 'On this ward, the sister and trained nurses: Provide an atmosphere which is good to work in; Are concerned about what a student is thinking or feeling; Are available and approachable'. Section C rated 'Ward Teaching' on ten items. These items included statements such as 'Sister devotes a lot of her time to teaching learners; Clinical teachers teach regularly; Consultants are interested in teaching; Trained nurses teach

as they work with learners; Learning objectives are in use on this ward'. Section D rated 'Provision of Learning Opportunities' on six items such as 'Trained and learner nurses work together giving a full range of care, e.g. bathing and dressing; Sister attaches great importance to the learning needs of student nurses; Learners are given an opportunity to use their initiative and discretion'.

Section E related to 'Patient Care' and contained five items. These items asked students to respond to statements such as 'Sister promotes good staff/patient relationships; Patients get plenty of opportunity to discuss their feelings and anxieties; Patient allocation rather than task allocation is the practice on this ward'.

Responses to each statement on items 1-35 were on a 5 point Likert scale from 'strongly agree' (5) to 'strongly disagree'(1). Section F, on 'Anxiety and Stress', asked students to tick whether they experienced anxiety or stress: 'Frequently'; 'Occasionally'; 'Not very often'; or 'Never', whilst working on the ward. Students were awarded a score according to the frequency with which they experienced stress or anxiety from 3 (Frequently) to 0 (Never).

There were also five open-ended questions at the end of the questionnaire which asked students for general comments on ward learning. They included questions on causes of stress or anxiety; identification of most valuable and least valuable educational experiences; suggestions for improving teaching and learning and an opportunity to make any additional comments about the ward.

The questionnaire was self-administered and had been tested for reliability and validity. In terms of validity of the questionnaire, Fretwell (1985) argued that it had 'content validity' because it was based on previous research findings (Fretwell 1978, 1982). Items on the questionnaire which were said to be indicators of a 'good' learning environment were validated by other researchers (Orton 1981, Ogier

1982). Fretwell also found that comments made in questionnaires and during informal conversation with trained and student nurses confirmed its validity as a tool for evaluating the ward learning environment.

Fretwell ran a number of reliability tests on the questionnaire, and on a shortened version of it, which was used in the present study. Both the 'test-retest' method and 'alternative tests' were applied since there was no guarantee that the ward conditions would remain stable during the period in which the questionnaires were administered. The questionnaire showed that it stood up to 'test-retest' reliability on the pilot ward since the ratings of the learning environment remained constant over a nine month period. However, in order to overcome the problem of changing ward environments interfering with the reliability test-retest method, Fretwell also administered the questionnaire to two different groups of students with similar ward experiences. The students were randomly selected to one of two groups. Scores for a random selection of five questions were compared. The wards were then ranked on the basis of these scores and a perfect correlation between the two groups was noted. Further analysis was carried out on a further three questions, when there was some disparity of opinions on wards or clear discrimination between them. Analysis of the resulting 40 scores (8 questions for 5 wards) showed similarities between groups. Overall scores for the eight questions were calculated, showing a significant correlation of 0.9 at the 0.05 level.

Spearman rank correlations were used to analyse relationships between each question, the total score and the 'split-half' method. The 'split-half' method was used in which the range of items were split into two halves and total and mean scores calculated for each half. Reliability was again confirmed when the range of difference in the mean scores was low, from 0.01 to 0.21. There was also a correlation of

0.94 between the two rank orders, which was significant at the 0.01 level.

The questionnaire was shortened and similar tests of reliability were applied, achieving similar results. Fretwell concludes that, on the basis of extensive testing, the Ward Learning Environment Rating Questionnaire (long and short version) was a valid and reliable measuring instrument.

3.3 Research Procedure

3.3.1 Organisation of the research

The study was organised in four phases. For clarity, they are categorised and described as if they were distinct and took place sequentially. However, in practice, there was some degree of overlap between each phase.

Phase one: January 1984 - June 1984: exploratory work on a variety of hospital wards. Three months were spent on one medical ward participating and observing the practice and learning of nursing. A variety of research tools and methods were tried out in order to explore ways of conceptualising the variables (quality of nursing and the ward learning environment) and to select appropriate techniques, settings and subjects for describing and explaining their interrelationship.

Phase two: April 1984 - June 1985: the school of nursing. During the first few weeks of this phase of the research, volunteer groups of students were interviewed and discussion groups held to identify topics to be addressed during interview. Teachers were also interviewed. The Fretwell (1983, 1985) rating questionnaire on the ward learning environment was tried out with four groups of students at different stages of training. All the students were undertaking medical nursing in modules 1 and 3 (first years) and modules 12 and 14 (third years). Preliminary analysis of questionnaire data yielded valuable findings,

and confirmed the usefulness of the instrument as a measure of students' perceptions of the ward learning environment. It was decided therefore to continue using the questionnaire as a method of data collection.

Classes were observed and decisions made about which ones to select to observe in depth. The content of timetables for the medical modules was recorded and analysed. A first and third year group of students were selected for observation (sets A and B respectively) and a random sample from each was recruited for interview.

Phase three: November 1984 - June 1985. Three in-depth study periods on selected medical wards of eight weeks, during which the researcher participated in and observed the practice and learning of nursing using instruments and methods from the exploratory phase of the study.

Phase four: July 1985-1987. Final analysis and writing.

The following sections (3.3.2 to 3.3.5) describe in detail the research procedure adopted by the researcher and the integration of the strategy and techniques described in sections 3.1 and 3.2. The first person is used in the following sections for three reasons. Firstly, 'to write oneself in' to the account, thus challenging the 'mythology of "hygienic" research' exposed by feminists (Oakley 1981, Bell and Roberts 1984). Secondly to capture the spirit of grounded theory in the generation of conceptual categories, their properties and working hypotheses about quality of nursing and the ward as a learning environment. And thirdly, to illustrate the negotiation of the research role as a continuous process throughout the research. Although not intended at the outset of the account, the hierarchical, defensive nature of the relationships among nurses is also demonstrated through the interactions that took place between researcher and researched.

3.3.2 Details of subjects studied

Details of the subjects studied are given, according to the research techniques for which they were recruited, following Denzin's multimethod research strategy outlined in section 3.2.

Survey interviewing:

Questionnaires on the ward learning environment ^{1 2}

524 rating questionnaires were completed by 392 learners from 19 sets, with respect to 12 medical wards. Details of the medical wards are given in chapters 1 and 5.

132 learners from eight sets completed the questionnaire twice. Another 43 learners from the same sets completed the questionnaire once. 217 learners from 11 different sets completed the questionnaire once from May 1984, finishing in June 1985.

A total of 142 questionnaires were completed for module 1, 125 for module 3, 118 for module 12 and 139 for module 14. In all, questionnaires were completed by a total of 188 first year students and 204 third years students. Response rates in the first year and module 12 were almost 100 per cent. The non-response rate for senior third years was 25 per cent. One reason for the drop in response rates at the end of module 14 was that classroom sessions were no longer compulsory.

The majority of the respondents were female. However, in the sets who filled in the questionnaire 10 of them were men, representing the maximum number of male students who could have filled in the questionnaire at least once.

The data yielded from the open-ended questions at the end of the questionnaire (questions 37-41) were based on the stratified random sampling of students' comments on question 38. A baseline of ten comments per ward from students in each module was sought. A total of 79 respondents were selected, which yielded: 20 replies from module 1

students; 19 replies from module 3 students; 21 replies from module 12 students; and 19 replies from module 14 students. The stratified random sample of replies to question 38 represented 15 per cent of the total questionnaire population. Not all of the 79 respondents who commented on question 38 commented on the remaining questions (i.e. 37, 39-41). The total number of replies for each question was: Question 37, 57 replies; question 39, 52 replies; question 40, 68 replies; question 41, 48 replies. Some respondents made more than one comment on each question.

Interviews

The student population:

The student sample comprised 18 volunteers, 8 students who had been approached by the researcher, and 15 students who had been randomly selected from the first and third year of training.

First year students

In summary a total of 16 first year students were interviewed, in group, in pairs or individually. 4 students were interviewed three times, 1 twice and 11 once. The interviews were conducted during modules 1, 3 and 4. 4 students in the random sample from set A were involved in one discussion group. In addition a total of 12 students (two of whom were also interviewed) from another set took part in three group discussions during their first year medical ward allocation.

Third year students

A total of 15 third years were interviewed. 10 were interviewed once and 5 three times. Ten interviews were conducted at the beginning and end of module 12 and fifteen during module 15 at the end of training.

There was only one male interviewee in the whole sample out of a potential of four male students in the sets from whom the interview/discussion group population was drawn. The age range of the group was 18-24 for first years and 20-28 years for third years.

Details of parents' occupations were not available for all students but they included a number of fathers who were doctors, an accountant, a managing director, a press officer and a print worker. A number of mothers were nurses. All students were British and only one was non-white.

All the students had the minimal educational qualifications for entry to the City school of nursing of 5 'O' levels and at least one 'A' level pass. Four of the students were also university graduates.

The ward sisters:

The sisters on all four study wards agreed to be interviewed. Their ages ranged from 28 to 38 years. They had been in post from three to ten years with a mode of four years. Three out of the four sisters had undertaken post basic nurse education in intensive care nursing. One had a degree and two had trained at the City hospital. The two other sisters had also trained in London teaching hospitals.

The nurse teachers

In total five tutors from Unit 1 were interviewed and four tutors from Unit 3. One clinical teacher was interviewed as the sole representative of this group, the others having left the City school of nursing during the study. One psychiatric tutor was interviewed because of his input to the Foundation Unit. Interviews were also conducted with the Assistant Director of Nurse Education (ADNE).

A total of eleven nurse teachers were interviewed. Three had degrees, two had trained at City hospital and all had undertaken postbasic nurse education in addition to nurse teacher training. Their ages ranged from 30 to 50 years.

The patients

The biographical details of the patients are given according to the wards on which they were interviewed and from where they were discharged.

Edale ward: Only three patients were interviewed. All were male. Two were over 75 and the other interviewee was 34.

Windermere ward: Ten patients were interviewed. All were female. Their age ranged from 41 to 81.

Ronda ward: Eight patients were interviewed. Seven were men and one a woman. Their ages ranged from 26-86.

Kinder Ward: Ten female patients were interviewed. Their ages ranged from 30-85. In summary, a total of 31 patients were interviewed. They could be characterised as white, lower middle and middle class, based on their occupations. A number of the older respondents were retired. Only two of the respondents were non-British. Their length of hospitalisation varied from two days to eight weeks and they suffered from a variety of acute and chronic conditions. Some patients were suffering from life threatening conditions such as lymphoma and advanced coronary artery disease. Others had been admitted for investigations.

The details of the patients in the QualPacs sample are given by ward and session. No reliable QualPacs data were obtained for the first study ward and so details of patients are not given here. The other wards were observed for three sessions each.

Windermere ward: A total of 12 patients were observed on three occasions. One patient was observed on two occasions. The patients had an age range of 22-95 years and a variety of diagnoses and dependencies.

Ronda Ward: A total of 13 patients were observed on three occasions. two patients were observed on two occasions. Their ages ranged from 19-78 and they suffered from a variety of diagnoses and dependencies.

Kinder ward: A total of 11 patients were observed on three occasions. One patient was observed on two occasions. The patients' ages ranged from 64-94 and they had a variety of diagnoses and dependencies.

The patients observed were more likely to be categorised as medium or high dependency patients requiring a number of nurse-patient interactions associated with physical and technical care. On Kinder ward, the patients observed during the QualPacs sessions were more likely as a group to be elderly, compared with the patients on the other two wards.

Non-participant observation in the school of nursing

During non-participant observation in the school of set A's Foundation Unit, Modules 1 and 3, a total of 26 from a potential 238 sessions were observed. A total of six nurse tutors were observed. The majority of them were Year 1 tutors.

Examination of biographical information for set A yields the following data: Twenty students in the group, including one male student, with an average of 8 'O' level and 1.8 'A' level subjects. Their ages ranged from 18-22. By module 3, 3 students had left, including the one male student.

Non-participant observation in the school during set B's Modules 12, 13, 14 and 15 included 39 sessions out of a potential 124. A total of five different nurse teachers were observed. The majority of them were Year 3 tutors.

Examination of biographical information for set B yields the following data: A total of twenty-nine students, including three male students, with an average of 7.5 'O' levels and 1.7 'A' levels. They included two graduates. The students had an age range of 20-28 years and were generally regarded as having an above average age range for a group of student nurses; the majority of the set were not direct entrants to nursing from secondary school. They were therefore not regarded as a representative group of students for City school of nursing, most of whom had come directly from secondary school to start training.

Observer participation

On each of the four study wards, the ward establishment of trained staff in addition to the sister varied from eight staff nurses on Kinder ward, six on Ronda ward and five each on Edale and Windermere wards.

Each ward had an average allocation of ten student nurses during their first and third year medical modules. Numbers varied in each module according to size of the set, from zero in some instances to three in others. In an eight week observation period, the researcher would expect to have contact with an average of seventeen nurses at different stages of training. Details of the student population on each study ward who participated in interviews, discussions and field observations are given below.

Edale ward: There were nine students in all, including one each from both set A and B. The distribution across the modules was as follows: module 1, three students; module 3, two students; module 12, one student; module 14, one student; and two students from the final module 15.

Four ward based discussions were held, three with people in the same year of training (one first year and two third year groups) and one mixed group of first and third years.

Windermere ward: There were four students in all who took part in interviews. In module 1 there were two students (both from set A); none from module 3; two students from module 12, one being from set B, and none from module 14.

Additional data were yielded by discussions in the school of nursing at the end of the allocation, with two first warders, two third warders and a student from module 12 during a critical incident session.

Ronda ward: In addition, there was a third module student who volunteered for interview following distribution of the questionnaires

on the ward learning environment. There were five students in all: module 1, one; module 3, three; module 12, none; and module 14, one. Four of the students were from either set A or B.

A ward based discussion was held for three students from modules 1 and 3.

Kinder ward: There were five students in all: module 1, three; module 3, one; module 12, none; and module 14, one student. Two of the students were from sets A and B. A school based discussion included two first warders at the end of their allocation to Kinder ward.

A number of students featured in all data sets described above, i.e. survey interviewing; document analysis; direct observation and observer participation. Others appeared in one to three of the sets. The choice of techniques, settings and subjects permitted the students as the principal actors to be well represented in the study.

3.3.3 Phase one: The research setting, access and preliminary negotiation of the research role

The City Health District in general and the City hospital in particular had undergone many changes of organisational structure and personnel during the period immediately leading up to the study.

In November 1983, before the new structures had finally been confirmed, the appearance of the Griffiths report (DHSS 1983) generated further uncertainty as to the future of consensus management teams in all health districts. The development of appropriate management structures and the appointment of general managers continued throughout the study period and was not completed until after the data were collected.

Throughout the research, there was a feeling of uncertainty amongst all grades of nursing and other staff about the future of the National Health Service (NHS) in general and their own future in particular. This was evident by the increase in trade union activity opposing the changes and cutbacks during, for example, District Health Authority

(DHA) meetings. The Royal College of Nursing's (RCN) involvement in opposing the changes was also reported in the nursing press.

In City District as a whole, major reorganisation of general management and nursing structures had been undertaken during the previous year. Two major teaching hospitals, City and County, were now situated in the same health district, competing for the ever diminishing central government funds.

Thus I entered an atmosphere of uncertainty and insecurity added to by my own unusual position as paid employee and independent researcher. I was already viewed with some suspicion by both nurse managers and teachers, because they believed that the study was receiving the backing and support of the chief nursing officer (CNO).

City hospital's nurse teachers were feeling particularly defensive and vulnerable as a group, following a series of unfavourable reports and the proposed amalgamation with the County school of nursing. Indeed, one of the reasons for the CNO's interest in my research stemmed from her concern to be seen to be 'doing something' about improving nurse training. The association between the unfavourable reports and my appointment was not lost on the teachers. They were reported by an independent observer to be 'up in arms' about my appointment, describing it as 'the last straw'. As if to confirm the association between my appointment and the unfavourable reports, my first week in the district coincided with the inspectors' follow-up visit. I was also told on my first day that the ADNE was 'furious' about my appointment, claiming that she had not known anything about it.

Because of the apparent hostilities and anxieties surrounding my appointment, therefore, I decided to keep a low profile in relation to the school of nursing during the first three months of the study. Later, following a placatory discussion with the ADNE, it was agreed that I should contact her when I felt ready to address a staff meeting

at the school. This meeting eventually took place in April 1984.

Since the focus of my study was the student nurse in the ward environment, I wanted to gain access to the wards at City as quickly as possible. Soon after my appointment, I was taken to meet the sisters on their wards by a senior nurse who had worked at City hospital for fourteen years. It was during the ward visits that I met Sister Edale, who said to me as I left her ward 'Come back any time'. Because of her positive response, I returned three months later to ask if her ward could be used for the exploratory study.

Some weeks later when I was asked to explain the purposes of my study to a senior sisters' meeting, I thought I saw some of the sisters exchanging 'negative' glances whilst I was speaking. However, when I expressed my concern to the director of nursing services (DNS), who had been present, she pointed to the group of sisters walking away talking animatedly about something else. 'Oh don't worry,' she said 'they'll have forgotten about you already'. This comment was both reassuring and alarming. As I was later to find out, sisters and nurses had so many activities going on around them on the ward that an unknown researcher very quickly became assimilated and taken for granted. However, following the senior sisters' meeting I decided to go and see each of them individually to discuss the research with them and to assess whether they were interested in becoming involved in field work. Through all the early uncertainties, City's DNS was consistently supportive and helpful. She offered me 'open access' to all wards and departments of the hospital. The medical staff were informed of my research by the City/County Unit DNS to whom I was accountable, during a routine meeting of the medical advisory group. No formal ethical clearance was considered necessary since the research was seen to be concerned primarily with nurses and their learning.

I attended senior nurse managers' meetings, at the invitation of the

DNS (City/County). These meetings were invaluable, both for keeping me informed of the changes taking place within the district, and as a means of observing nurse managers' reactions to these changes and the daily demands of working in a busy district. However, I was able to develop the study independently from the managers' influence. I protected myself from giving feedback to nurse managers by explaining that this could distort the findings; also that I did not want to breach the confidence of my informants.

In general, I developed a strategy for defusing defensiveness by stressing the ward based aspects of my study when describing it to tutors. To ward staff I emphasised the 'theory-practice' dilemmas of nurse training. I avoided emotive terms like 'standards of care' when discussing quality of nursing. Thus I merely shifted the emphasis of the research depending on whom I was speaking with.

During my first months in the field, I was frequently reminded of Towell's (1975) observation that the researcher's perceived position in a hierarchy affects the people, information and settings to which s/he has access. Thus, I found myself negotiating my way through the tensions that existed between the different groups without being seen to be allied to any of them, i.e. the CNO, nurse managers, tutorial staff, ward staff and students.

The negotiation of my 'non-aligned' role was facilitated by being allocated an office on 'neutral' ground. The office was close to the medical wards and at some distance from both the department of nursing administration and the school of nursing.

Preliminary exploration or first days in the field

(a) On the wards

The first three months of the exploratory phase of the study were used to decide on criteria for selecting wards in which to explore quality of nursing and the learning environment. The literature

reviewed in chapter 2, section 2.2.2, suggests that ward specialty, workload and patient gender might be important in terms of student learning. I was also interested in the ward sisters' approaches towards student learning and patient care. I decided to select wards for the initial exploration of the research problem that offered a variety of specialties, bed number, gender mix and ward sister approaches to nurses and patients. These wards included: a male cardiology ward, a male gastroenterology ward, a female gastroenterology surgical ward and a mixed sex rheumatology/opthalmology ward classed as a surgical allocation for nurse training. Oncology and neurology wards were excluded because of the stressful and sensitive nature of the work.

After some thought as to what I should wear whilst on the wards I decided to wear a senior nurse's uniform: a navy blue dress and no hat. Tutorial staff also wore this uniform and it was not uncommon to see people wearing it on the wards. I decided therefore that the uniform should not make me too intrusive. Occasionally patients, relatives and other visitors thought I was the ward sister. Students assumed I was a tutor until I informed them otherwise. Few people read my name badge 'Senior nurse (Research)' but occasionally I was asked by patients and their relatives about the meaning of my title.

Having selected wards for the first half of the exploratory study, I went to see each ward sister individually. I described the research as aiming to build up a picture of how students learnt in different wards and if they related 'theory' learnt in the classroom to 'practice' on the wards.

I outlined the objectives for coming to their wards over a two shift period. Firstly, I wanted to orientate myself to nursing at City; secondly I wanted to work on a variety of wards to help me to decide which wards to select for more in-depth study; and thirdly to look at ways in which I might work as a research nurse. I wanted to work

primarily as a participant observer, nursing patients both independently and with students.

I arranged to be on the ward on two consecutive days when the sister was on duty . Being on a late shift (12.45 to 21.15) followed by an early shift (7.45 to 16.15) gave the greatest continuity. For example, the same staff and patients tended to be on the ward for this period.

I decided to work on the ward when the sister was on duty in order to observe her approach to nurses and patients, to reduce the variability in an ever changing ward environment, and because I assumed she would be more comfortable relating to an unknown researcher than a less experienced staff nurse. These basic rules of procedure, established in the first days in the field, were used later on wards selected for in-depth study.

I enjoyed the shifts and found working in this way much more satisfying and involving than working for a three hour fragment as I had done as a tutor.

I also found that I expended energy trying to be a 'good' nurse so as to gain credibility with the ward nurses. I considered that in order to 'prove' myself I needed to get through the work quickly and efficiently. I realised that I was setting myself up as 'super-nurse' who never made mistakes. I was becoming too pre-occupied with the finer details of nursing technique rather than gaining insights into the role of participant observer and the processes of nursing and learning.

I also needed to work out how much I should intervene in nursing practice on the ward. This question arose when I saw students undertaking an aseptic dressing and using scissors that had not been sterilised to cut gauze that was to be applied to a patient's wound. I did not want the students to feel that they were being criticised nor to confuse my research role with influencing ward 'norms'. I finally decided that as long as patients' and nurses' safety was not at risk I

should not intervene.

I also experienced other dilemmas related to how much initiative I should take in relation to direct patient care. For example, on one occasion I responded to a patient's request for information on a blood test he had undergone. He had been told on a ward round by a doctor that the test would have to be repeated without being given any explanation why. The patient was concerned that the first test might have yielded abnormal results. He also wanted to know the significance of the findings in relation to his condition. After giving thought to this and similar situations, I decided that in the future I should refer such matters to the sister since I was not there to run the ward.

However, the extent to which I became involved with patients and nurses in the subsequent study wards changed, following a shift in emphasis from participant observation to participant comprehension (Collins, 1984). I no longer sought to minimise my interactions with participants in the research setting, but use them to understand the 'native culture' on each ward. For example, the way in which I interacted with patients and nurses depended to a large extent on each sister's style of management. As illustrated in section 3.3.5(a), the negotiation of the research role was a continuous process and varied from ward to ward and situation to situation.

I was surprised at the ease with which sisters and nurses, particularly students, integrated me into their daily lives. This reaction may have been partly because new people (staff, patients and visitors) were constantly moving through the ward. Also the 'extra help' I was able to give was always welcome.

In general, the students supported a study that was concerned with them and their learning needs, but they did have some reservations at first. As one student explained: 'We (students) found it off-putting having you around because we thought you were a senior tutor checking

up on us. When we realised you weren't we enjoyed working with you'.

The sisters expressed fears of being criticised and two of them hoped that the research findings would not be critical of them. Of the sisters who were more relaxed about my presence on the ward, one was involved in her own small research project and the other had been a student in the previous hospital where I had worked.

Only one sister did not invite me to have coffee and meal breaks with the staff in her office (she was one of the sisters who had expressed explicit fear of being criticised). She told me that she 'studiously avoided' me and asked the students to take me to meals with them. I found this a satisfactory way of seeing the world from their point of view. On the other hand taking coffee and meals with trained staff helped me to gain insights into their perceptions. On account of the sister's defensive reactions, I decided not to approach her to do any further research on her ward.

No doctors asked who I was and domestic and paramedical staff reacted to me as if I were one of the ward nurses.

The above account of the first days in the field is important in that the strong hierarchical structure within nursing becomes apparent in the research role negotiations between myself and other nurses. The fear of criticism by senior nurses, and my own response to internal and external pressures to work quickly and efficiently, were indicative of the reactive and defensive behaviour induced by these structures.

(b) Recording the data

I kept detailed notes of each shift which I wrote up in my office at the end of each period on the ward. I did not make notes whilst on location except during the staff handover reports about the patients. Writing down verbal information was seen as a legitimate activity for all who were receiving the report. It was possible to note the way in which ward sisters allocated the work, which grades of nurses looked

after which patients and what priorities were given to particular types of care. It was also possible to note patient diagnosis, age, dependency and medical intervention.

At first I was not sure what I should be recording about a day on the ward and, like James (1984), I recorded everything that I recalled, afraid I might miss something of importance but also aware that I might be selective in my recall. Since I wanted to develop working hypotheses from the data, it was important not to constrain my data base.

From these early beginnings I was able to see issues and data collecting strategies emerging from the fieldnotes, which were to shape the future research. These emergent issues and strategies are outlined in the next subsection.

Narrowing the field

Following my exploratory visits to a variety of wards and noting the scope of the data obtained about the quality of nursing and learning I was able to make decisions about how to develop the study further. For example, I noted that two specialist medical wards (cardiology and gastroenterology) produced different ward environments for student learning in terms of the learning material. Turnover was relatively predictable, as on the surgical wards, since patients were admitted for planned investigations some of which required minor surgical intervention. However, since these wards also included beds allocated for the care of general medical and geriatric patients there was also an element of unpredictability and variability in the workload.

I decided to narrow the research field to medical wards only since there appeared to be sufficient variability of learning material without including surgical wards as well. Furthermore, it would mean that the students would be at the same stage of training. It was also becoming apparent that if I wished to explore the relationship of 'theory' to 'practice' it would be easier to do this with students

undertaking either medical or surgical nursing experience rather than both. I could also compare groups more easily at different stages of training. First and third year differences in terms of the quality of nursing that they gave and their learning needs were beginning to emerge as important variables to study.

In summary, therefore, on the basis of data obtained during the first days in the field I decided to narrow the study to medical wards for the following reasons: In the City hospital, medical wards were the first and final wards where students were allocated in their training; the variety and patterns of care appeared less predictable than on surgical wards; senior students' management skills were assessed. Since students undertook four medical modules during training (two in the first year; two in the third) it was appropriate to select four medical wards in order to study them at each stage of training. I decided, therefore, to select one medical ward to develop in greater detail the methods of data collection and working hypotheses. The interplay between the collection, coding and analysis of data and the shaping of ongoing data collection in developing grounded theory was thus demonstrated.

Exploratory ward case study

The second half of the exploratory phase of the study lasted from March to June 1984 and was based on one male medical ward. I approached Sister Edale because she had reacted so positively to me when we had been introduced during my early visits to the wards.

Edale ward's reputation as an acute busy general medical ward, specialising in endocrinology, also recommended it as providing interesting learning material for students. Its other recommendations as a study ward included its internal rotation shift system that was gradually being introduced to the rest of the hospital, and its small (16 beds) and compact layout.

The sister had only a vague recollection of who I was. We arranged to meet so that I could explain the study to her and to see if she was interested in participating. She was interested in research and was generally approving of the qualitative methodology that I was adopting, since in her view nursing's complexity made it difficult to quantify. The sister thought that her staff nurses would agree to me coming as they were 'research-minded'.

She also asked whether I was interested in the 'care' of students as well as patients. Her question made me realise that I should have explicitly considered the care of students as part of the research problem. I then began to integrate it into the study.

I was invited to spend time on the ward 'to see if I liked it'. I used this time (March-April) to get to know the ward and to become familiar with 'the work culture' defined as 'an observable regularity in the assumptions, attitudes and behaviour' of staff as they carry out their work (Bain 1982). I also used it to negotiate my role as a participant observer and develop an overall research strategy for the period on the ward.

On subsequent study wards I used the first days as an exploratory period for noting the 'work culture' and negotiating the research role. The differences among wards were noted as an indicator of the sisters' management styles and their approaches to quality of nursing and student learning.

Working as a participant observer was indispensable for internalising and reflecting on what it was like to nurse patients. It had a compelling immediacy of experiencing the anxiety, pressure and expectation to perform 'well'. There were difficulties of not feeling in control of the work when nursing patients for the first time, especially after a few days away from the ward. I also experienced the boredom of routine tasks such as four hourly observations (temperature,

pulse, respiration and blood pressure), measuring and charting fluid intake and output and testing urine. Often I questioned to myself whether these observations needed to be recorded so frequently but preferred to observe ward 'norms'. Later in the study, in the spirit of participant comprehension, I would enquire as to whether certain patients' observations could be taken less often.

One third ward nurse commented to me that she did not think it was 'fair' that as a 'senior nurse' I should still be doing what she saw as 'students' work, namely routine bed baths, toileting, feeding and observations. 'You've been through all that!' she said. By implication she was downgrading 'basic', routine work to the province of students rather than trained staff.

Patient dependency and turnover were high on the ward and the variety of conditions considerable. The psychological care of drug addicts, the needs of the dying and the drama of respiratory arrests were particularly demanding and unpredictable. The changing workload and the variety of patient conditions began to suggest to me their importance in terms of perceived student learning material and how learning was defined and made available to them.

The sister invited me to take coffee and meal breaks in the office. She considered this arrangement 'more in keeping with my age and status' than going with the students to the dining room. She may have also felt more secure having me in her social circle rather than in the students'. I found the breaks gave insights into the trained staffs' views of nursing and students' learning; also their preoccupations and concerns as nurses and as people.

I was not usually expected to take an active part in conversations except when information was sought about the research. The breaks were used by the staff as occasions to unwind and reflect on what was going on in the ward. They were also used as 'work' meetings to discuss items

of patient and student management.

After a few weeks I attempted to go to lunch with students. One senior student said: 'You're playing the student role this week, are you? It must be quite difficult not being one (trained staff) nor the other (students). We're secure in our roles'.

Taking meals with students was not very successful and they hurried away to the sitting room or their own rooms after eating. They clearly needed a 'break' from the ward and it is possible that they did not relax with me because they associated me with the trained staff as well as an 'unknown' researcher.

However, within the ward, both students and staff grew accustomed to my presence and appreciated my help on busy shifts.

The junior students particularly began to approach me for advice. A senior staff nurse expressed surprise at their willingness to approach me. She reflected on her own recent student days during which she claimed she had avoided trained staff whenever possible. The sister offered an explanation for the students' willingness to approach me: 'They put you somewhere between the third years and the trained staff. They don't feel threatened by you because you don't have any authority over them!'

The sister was the only person on Edale ward who admitted to feeling threatened. She supposed 'It's because I feel I'm being put on the line, as I'm responsible for the ward'. A few weeks later she was able to say 'Because I know you better I now think of you as "inquisitive" rather than a "threat" '. By the end of the preliminary ward period, she had become sufficiently interested in the study to want to continue with it, especially on being assured that I felt 'comfortable with the way we do things on the ward'.

With the exception of a house officer, a consultant and a dietician who invited me to her tutorials, ancillary, paramedical and medical

staff did not enquire who I was.

The house officer was a regular social visitor to Edale ward, joining staff for meal breaks and joining in discussions about work and other issues including my research. On one occasion, a consultant noticed me undertaking 'non-participant' observation. The sister told me that he assumed I was doing a 'time and motion' study.

The ancillary and paramedical staff's reaction was consistent: they treated me as one of the ward nurses. Ancillary staff were always friendly. For example, they offered me drinks during non-participant observation and interviews with patients if they were coming round with the patients' drinks trolley.

(a) The emergence of a research strategy: At the end of the first month on Edale ward (11 contact days) a research strategy was beginning to emerge. I decided to focus on students undertaking one of four medical modules during their allocation to the study ward. As Edale was the first study ward I focussed on students in module 1. I visited them in the school of nursing prior to their allocation to the ward and interviewed them. I also asked for volunteers, and later a random sample of students other than those on the study ward, to talk to me about their experiences of nurse training, in the ward and classroom. I undertook both individual interviews and group discussions.

During the students' eight week allocation (a total of 56 days) I was on the ward for two or three days weekly in order to participate on the same shifts with them (16 contact days). In the first instance I focused on module 1 students, but on the subsequent wards I observed module 12, 3 and 14 students respectively. Students other than in module 1 were 'absent' from the wards for up to two weeks at a time because of periods spent on night duty (seven nights) followed by off-duty (six days). I decided therefore that since the students spent so much time on night duty it was necessary for me to spend up to two

shifts on nights whilst I was on the ward. Although this was a short period of time it gave me an opportunity to observe the activities on the ward at night and the amount of responsibility placed on students. The sister drew my attention to students in their third module who were experiencing night duty for the first time. I therefore decided to observe night shifts when third warders were on night duty.

In addition to the many informal conversations I shared with students as we worked together or during the occasional breaks, when I extricated myself from the trained staff's social circle, I also arranged informal discussions with all the students on the ward.

After four weeks on the ward, the study students were half way through their allocation. This seemed an appropriate point at which to interview them about their ward experiences to date.

I found however that, because I focused on students from a specific module, I did not find sufficient opportunity to observe how students from other modules were experiencing the ward. For this reason, on future wards I chose the fourth and fifth weeks of a student's allocation in all modules as a period to be on the ward to work with them and observe their activities. I also arranged to be on the ward when new students were beginning their allocation in order to observe if they were given any orientation to the ward.

I wanted to withdraw occasionally, to become a non-participant, since the momentum of the ward as a participant sometimes left little opportunity for an overview. The most suitable way of becoming a non-participant seemed to be by adopting techniques used by other researchers as non-participant observers. I tried out one such technique, described above - the QualPacs (Wandelt and Ager, 1974) - after I had been on the ward for a minimum of one month and when the students were at their halfway period on the ward.

I told the nurses and patients that I was not undertaking nursing

duties that day, and that I wanted to observe what was going on in the ward from the 'sidelines' rather than always being involved in the work. I asked permission to go behind curtains or into bathrooms and toilet. During the observation I found great difficulty in resisting the temptation to 'just make a bed' or 'quickly help lift a patient'. At the end of the session I discussed with the nurses whether they thought the shift had been 'typical' and whether they had been aware of me observing them. The sister said she had been aware of me at first but added 'I'd become dysfunctional if I kept thinking about you all the time!' A staff nurse said that every time she saw me she made a mental note to herself to 'communicate' with patients and students. Both the sister and the nurses, however, felt that because they 'knew' me and had become familiar with my presence around the ward they thought of me as 'just Pam' sitting in the corner whom they could forget about, rather than worrying about an unknown 'researcher'.

The first day of non-participant observation using QualPacs came to a dramatic conclusion after only one hour. A young drug addict collapsed following a respiratory arrest in the toilet. Resuscitation was necessary. The sister and other staff were on the scene within seconds. I was faced with the dilemma of carrying on observation or involving myself in the drama. I chose the latter, helping the nurses to draw up drugs and assemble the necessary emergency equipment. After the event was over and the patient had been successfully resuscitated I discussed with the sister and the nurses whether I should have involved myself. The sister thought it had not been necessary as there were adequate numbers of nurses on duty; a first warder thought that 'You couldn't not have helped'. The need to draw up a protocol to deal with such events became apparent. Following Lelean's recommendations I decided that cardiac or respiratory arrest, accidents due to falling or hot substances being spilled and intravenous infusions running through

should be clear indications for abandoning non-participation (Lelean 1975). I also decided, like Lelean, only to observe nursing activities that took place in the open ward, rather than invading patients' privacy behind curtains and in bathrooms.

After the disruption to my observation on Edale I decided to try out QualPacs with my supervisor on one of the wards I had visited during the first days in the field. One staff nurse made an interesting comment to us at the end of our observation period. She thought that students were so used to being continuously assessed during their training that they did not mind being observed by us. On the other hand, qualified staff who had trained prior to continuous assessment felt much more uncomfortable at our presence.

Our experiences with QualPacs on the additional ward left us with some reservations as to its validity and reliability as a measuring instrument of quality of nursing. Subsequent practice sessions with the instrument were set up and these are described in subsection (c) below.

On the basis of these practice sessions I later decided that if I increased the number of times I administered QualPacs on a ward from one to three times I could use it for observing both trained staff and student activity throughout my period on a ward rather than midway only.

I decided to use the Barr patient dependency checklist (Barr 1967) each day that I was on the ward in order to monitor workload and staffing levels.

I also planned to interview patients at specific times on the ward and thought that the third and final weeks would give me an overview of patients' perceptions during the total period that the study students and I were on the ward. But it became more convenient to interview a minimum of one patient weekly throughout the eight weeks, since patient turnover was relatively high. Like Coser (1962) I interviewed the

patients when they were scheduled for discharge, because they might feel less compromised in the answers they gave if they knew they were about to leave the hospital.

The ward reporting system and handover of information between trained staff and students were noted throughout my time on the ward, as well as formal and informal teaching sessions and allocation of the work.

Towards the end of my time on Edale ward I interviewed the sister using Pembrey's semi-structured agenda of questions on ward management, checklist of daily work priorities and problems and additional questions on the ward as a learning environment. As the interview and checklists provided complementary information on the sister's views of quality of nursing and ward learning I decided to use them on future wards. I had left the interview with Sister Edale until the end of my period on the ward in case in any way it might have influenced her subsequent behaviour. This did not appear to be the case. However, in the future I usually conducted the interview after I had been on a ward for sufficient time for the sister and me to be relatively relaxed with each other.

Once the students were back in the school of nursing I interviewed the study ward students and their volunteer colleagues (random sample on subsequent wards) about their ward experiences. I also distributed Fretwell's (1983, 1985) questionnaires to the entire class (see section 3.2.3(d) for description of the instrument; section 3.3.4, for discussion of school based activities). I found that these complementary techniques supplemented the data collected on the ward as a participant (Denzin, 1970).

I also sought archival information for the period spent on the ward on patient age, specialty, turnover and outcomes (death or discharge) and student nurse sickness.

(b) Recording the data: I used pocket size record cards to make notes on the ward during the handover reports at the beginning and end of each shift. I also filled in the Barr checklist of dependency which gave information on patients' age, bed occupancy and nursing needs based on daily living activities and treatment. I noted the number of nurses on duty; grade or stage of training; the patients they were allocated to look after and whether they were working alone or with another member of staff.

As the study progressed, I became more confident in my role as researcher, and rather than recording the major part of the data at the end of the shift, I used to sit at the desk writing up my notes. I continued to record data in this way on the subsequent study wards. Another reason why I felt able to do this was because many nurses became familiar with the research and no longer regarded either me or my activities with suspicion. Non-participant observations, interviews and discussions were recorded as they took place.

(c) Learning to use QualPacs: Following tryouts with the QualPacs measuring instrument, it was decided to contact nurses in Oxfordshire who were familiar with it. We were able to discuss experiences of using it in the field during a two-day workshop. In all the 'training period' averaged 14 hours followed by four practice sessions and discussion (totalling 21 hours). The number of hours spent preparing to use the instrument exceeded Wandelt and Ager's recommendation of two days of tryouts and discussion based on observation of up to five patients. We found, for example, that in four practice sessions we reached close agreement on the overall scores awarded for the quality of nursing observed during two hours of nurse-patient interactions. However, when we examined our scores further, we found discrepancies between the items used and how items were rated.

When individual item scores were aggregated and averaged, the

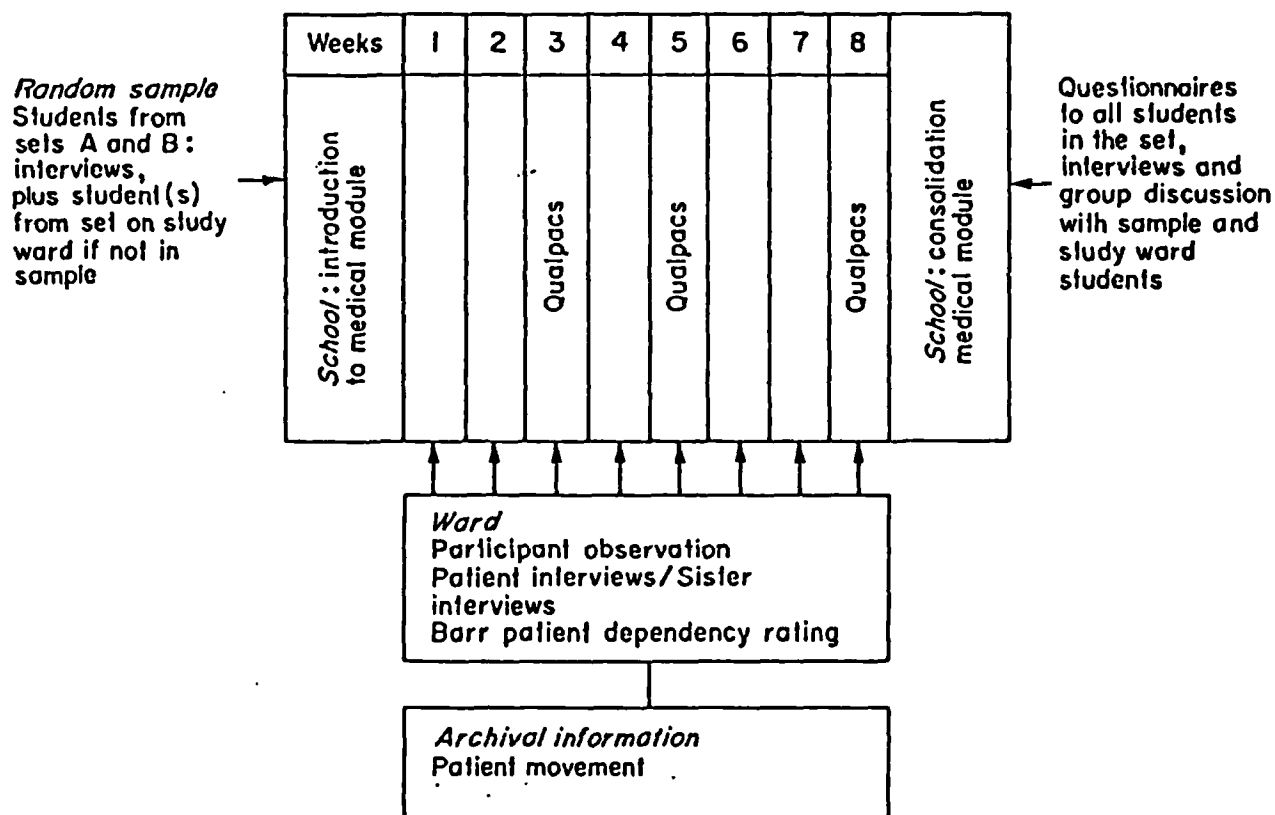
differences between raters disappeared. These findings suggest that the QualPacs instrument is so comprehensive that extremes of care and rater disagreements are not reflected in the mean scores.

Both at an intuitive level and on the basis of data collected during interview and participant observation, I found it difficult to accept that nurse-patient interaction could be finely operationalised into the items and scores defined by the QualPacs. Similarly, the maintenance of scrupulous objectivity in rating the items seemed like a contradiction in terms given that nursing is a subjective activity which involves feelings and emotions of the observer and the nurses and patients being observed. A single score may also be time dependent and not representative of overall quality on a ward nor reflect the ongoing relationships between nurses and patients, beyond the two hour observation period. My feelings were that the observer needs to observe patient-nurse interaction on three occasions.

Despite the limitations of the QualPacs measuring instrument and continued reservations about its validity and reliability, I decided to incorporate it into my study. I would observe as the single rater, since Wandelt and Ager (1974) suggest that one rater can use the instrument successfully. Participant observation provided the indepth insights into quality of care. The QualPacs provided a framework for structuring non-participant observation, an 'independent' measure of quality, against which to compare data obtained using qualitative measures, and an opportunity to put the scale under further scrutiny.

The methods used for exploring the variables of quality of nursing and student learning on the subsequent study wards are summarised in figure 3.1. The experience obtained on the exploratory study ward confirmed that a combination of qualitative and quantitative research methods was a manageable and meaningful way to explore the variables and their interrelationship.

FIGURE 3.1: SUMMARY OF METHODS



3.3.4 Phase two: The school of nursing

The second phase of the study began during the exploratory work on Edale ward and continued until the end of the data collection period on the subsequent study wards (April 1984 - June 1985).

Following a presentation of the research to school staff I was given permission to approach teachers and students to participate in the study. I constantly negotiated my role with them as I did whilst on the wards.

Since my time on the wards had led me to narrow the field to the study of medical wards only, I was specifically interested in associated classroom activities for students in years one and three. In year one, students undertook a six week foundation unit followed by an introductory and consolidation block before and after their medical ward allocation (wards one and three). In their final year of training study blocks before and after ward allocation combined preparation and consolidation for the previous and forthcoming placements. Medical ward experience came midway and at the end of the third year of training (modules 12 and 14) (see chapter 4 for plan of training).

The Fretwell questionnaire on the ward learning environment was distributed to four groups of students in modules 1, 3, 12 and 14 following allocation to twelve medical wards. Students' spontaneous reactions to the questionnaire were noted. Strict confidentiality was requested by students prior to filling in the questionnaires. I assured them that only I would see them in their unprocessed state.

The distribution of the questionnaires gave me an opportunity to gather data from a much wider source in terms of wards and students than the four study wards alone would have permitted.

I therefore arranged with tutors to distribute the questionnaires whilst students were in the school following completion of medical ward experience (modules 1, 3, 12, 14). This I continued to do throughout

the duration of the study. The questionnaire sample overlapped with students I interviewed and met during participant observation on the four study wards.

I arranged to interview all the tutors who were responsible for teaching first and third year students during the foundation unit and subsequent medical modules. I did not detect that the tutors were still 'up in arms' about my appointment, as they had been at the beginning of the study. They always appeared eager to talk and to co-operate, and made time available for me to see the students.

The students were equally co-operative and, as they had done on the wards, they welcomed a study that was concerned with their training needs. I began by asking for volunteers to form a discussion group about their training to date (Foundation Unit and Module 1). I then asked for volunteers from a student group at the end of their first year of training in order to interview them individually and in pairs.

I decided to interview students at the end of their third year of training to gain perspectives on third year training needs. I approached students from Edale ward who were about to take their final examination.

Although I found students ready to volunteer to take part in the study, I decided that it was possible that I was recruiting a 'self-selecting' group. I decided therefore to continue recruiting students through random sampling.

A group of finalists (module 14) who had filled in the questionnaire were also asked to co-operate in a random sampling exercise to recruit students for interview. All five of those selected agreed to participate, plus three other students who volunteered.

These early groups of interviewees were used to develop topics for the interview agenda and to explore the possibility of studying students longitudinally at different stages of training and in both interview

and ward settings.

By interviewing students alone, in pairs and groups I gained both individual and collective perspectives. I interviewed the students in a place of mutual convenience, such as my office, the school of nursing or their own flat or room in the nurses' home.

Subsequently I identified a first and a third year group of students (Set A and Set B respectively) whom I would be able to follow during first and third year medical ward allocations and associated school activities. The groups were chosen for convenience in that their training programme fitted in with my being able to accompany them in the ward and school throughout their medical modules.

Five students from each group were randomly selected for interview throughout their first and third year of training.

Selected classes and discussion groups which illustrated the interface between ward experience and teaching in the school for Sets A and B were also observed. Given emergent findings and issues identified in the literature, I was particularly interested in those classes concerning the nursing process, communication skills and classroom discussion of ward experiences. The students' timetables were also analysed for content.

During classes I sat at the back of the room, first having been introduced to the students by their teacher. Occasionally I was drawn into discussion by the teacher but I tried to avoid this by sitting outside her field of vision.

(a) Recording the data

Student interviews and discussion groups were either tape recorded or I took notes, depending on the wishes of the participants. Most students agreed to the use of the tape recorder and subsequent interviews and discussions were transcribed.

During classes, I took detailed notes of their content and method

and noted the rapport between teacher and students.

Using these methods I was able to describe the interface between ward experience and teaching in the school.

An eight week observation period on the three wards selected for the case studies, where at least one member of Set A or B was allocated, helped to build up a more detailed picture of this interface and its implications for quality of nursing and ward learning.

The emergence of working hypotheses

The exploratory phase of the study was equivalent to Glaser and Strauss's 'first days in the field', towards the end of which categories and hypotheses relevant to the research problem began to emerge. In the spirit of grounded theory, data collected by both quantitative and qualitative techniques were examined as they were collected in order to generate conceptual categories and working hypotheses. The following categories and hypotheses were formulated in the early stages of the study and shaped the ongoing data collection on three medical wards with students from Sets A and B. These hypotheses were used to build up a picture of the ward environment in relation to quality of nursing and student learning. In turn, these conceptual categories and their interrelationships were developed into the higher level concepts and substantive theory presented as findings in chapters 4-8.

The first working hypothesis and clusters of conceptual categories focused on the patients in the ward as generating particular types of nursing work and the students' learning material. Hence patients' needs were seen to determine the nature of the nursing work to be done in different wards and to constitute the learning/teaching material available to students. The students' judgement as to whether the teaching material offered by patients and their associated needs constituted a ward with a favourable learning environment was partly dependent on

their stage of training.

However, irrespective of stage of training, acute medical and surgical nursing was seen by them as more valuable for their learning than the care of elderly dependent patients. The view of the ward as a favourable learning environment was also influenced by workload and staffing levels. The heavier the physical workload in terms of 'basic' routine nursing care required by patients the lower was the quality of the learning environment in the students' eyes.

Emergencies, such as cardiac and respiratory arrests, investigations and technical procedures, such as complicated dressings and intravenous infusions, were all rated highly by students as positive learning experiences.

It was noted, therefore, that students continued to see their learning in terms of medical specialties and technical procedures despite the nursing curriculum's emphasis on the principles and practice of nursing encapsulated by the nursing process with its commitment to communication skills. However, doctors rather than sisters and nurse tutors continued to control the admission of patients to hospital and the nursing process was consequently seen by ward sisters, teachers and students as a device for organising work rather than nursing knowledge.

Although ideologically the nursing process is described in the literature and plan of training as putting patients and their needs at the centre of care, it fails to take into account the dual and potentially conflicting role of patient as provider of teaching material. In the students' eyes, patients may not fulfil their perceived learning requirements.

The second working hypothesis or cluster of conceptual categories considered the importance of ward management styles to the quality of nursing and the ward learning environment. A central feature in the

creation of a positive learning and caring environment appeared to be the accessibility and approachability of trained staff to students and patients. Although the ward sister was a key person, she alone did not create the quality of nursing or of learning. Her relationship to doctors and trained nursing staff, which in turn generated the social relations between trained staff, students and patients and the provision of teaching and learning opportunities, was also crucial. The sister's interpretation of the nursing process in handling information and feedback and prioritising care on the ward was also an indicator of certain management styles in relation to quality of nursing and learning.

The third working hypothesis or cluster of conceptual categories pertained to the principal actors in the study, the students, at different stages of training, each with their unique learning trajectory and personal life biographies. The quality of nursing they were able to give to patients was affected by their stage of training. On the other hand students' emotional and learning needs changed according to the stage of training; and different wards offered different experiences depending on the students' previous ward experiences, pattern of allocation, their previous learning in the school of nursing and their expectations for future learning.

3.3.5 Phase three: The case study wards

The conceptual categories and working hypotheses which emerged from the exploratory days in the field governed the selection of wards for further study. As noted in my decision to narrow the field (section 3.3.3) I decided to study four medical wards. However, I was interested in selecting wards that were different from each other and which provided varied nursing work and learning material for students.

The final selection of the main study wards was based on the patient mix by specialty, age and gender. The local reputation amongst nurses

of each ward in terms of patient population and the sister was also considered. The wards included the following:

Windermere, a female respiratory ward with an above average elderly dependent patient population and a reputation of being 'heavy' and physically demanding. The sister was well known for her commitment to the nursing process.

Ronda, a male gastroenterology ward with a few female beds and a reputation as a 'good' ward for students because of the variety of working and learning experiences it offered. I had worked on Ronda during the first days in the field and was interested to include it as a case study ward because it was a specialist medical ward (gastroenterology).

Kinder, a female cardiology ward with a reputation amongst students as a 'good' learning ward with a 'light' workload.

The three wards, together with Edale ward, gave the following mix: two female and two male medical wards; two specialist wards, one 'mixed' (Ronda) and one 'light' (Kinder); one general acute ward (Edale); one general high dependency ward (Windermere). Edale and Kinder were both reputed amongst students to be 'good' learning wards. Windermere was well known as a ward where the nursing process was practised. Ronda and Kinder wards produced a learning environment, similar to a surgical ward. Patients were admitted for planned investigations, requiring minor surgical intervention, and the turnover and workload was relatively predictable. All the ward sisters were willing to participate in the study.

On each ward I spent an eight week period to correspond to the length of time students were allocated to the wards. An initial period was spent negotiating the research role and becoming familiar with the ward culture.

(a) The negotiated research role on three study wards

Windermere ward

I felt very relaxed on Windermere ward. This was largely because of the sister's open management style and friendly approach. The sister was interested in the concept of peer group support and always regarded me as a peer and colleague. She was happy for me to do whatever I wanted in terms of research activity as long as I informed her at the beginning of the shift. Before going to Windermere I had designed a typed protocol for nurses and patients which explained who I was and what I was doing (appendix 1). The sister ensured that the protocol was firmly sellotaped to the ward desk so that all the students read it when they were on the shift with me and had the opportunity to ask questions. I also gave it to patients before a Qualpacs observation or interview and if they specifically asked who I was.

Often I was asked to do things: work with a first warder; arrange a patient's discharge; take the place of a student who had been sent to another ward. At other times when the ward was short staffed I gave the staff the opportunity to allocate patients for me to look after.

I involved myself in talking to patients and when one young woman became very upset I felt able to pull the curtains round her bed and have a long discussion with her about her problems. This was not regarded as encroaching on the trained staff's domain. Indeed, the sister positively encouraged nurses to spend time talking to patients and I felt able to do so because of that encouragement.

The ward atmosphere enabled me to organise my fieldwork in a relaxed way and to record the data sitting either at the ward desk or in my office. Students also became accustomed to me doing the dependency ratings and would offer to do them with me for their allocated patients.

Coffee and meal breaks were frequently missed by the trained staff

because of the volume of work generated by the elderly dependent patient population. Consequently they did not socialise among themselves on the ward nor with doctors who knew that coffee and tea was not as frequently available as on other wards. This meant that on Windermere ward I was just as likely to take meal breaks with students as with trained staff. The office was not regarded as an 'inner sanctum' as it was on the other study wards.

When I left the ward the trained staff said they had valued me being around, especially in terms of the support I had given them. They were also supportive to me.

Ronda ward

I never felt a part of Ronda ward, even though the sister had readily agreed to taking part in the research during the exploratory and main phase of the study. The fact that she never really saw me as part of the ward was summed up by her introducing me to doctors for a second time during my sixth week on the ward with the comment: 'This is Pam. She's doing some research here for a couple of days'. Neither was my research protocol displayed in a prominent place.

The workload was variable and at times unpredictable on Ronda ward. When the ward was busy, the staff would ask me to participate in patient care and to administer drugs and change intravenous infusions. When the staffing levels were low I was asked to work with a first warder on her first day on the ward.

When the ward was not busy, the sister suggested I do non-participant observation and patient interviews. She also liked to do the dependency ratings with me.

I was always invited to coffee and tea breaks on Ronda ward with trained staff and the doctors who were regular visitors. The sister liked the trained staff to take these breaks together and they were 'timetabled' into the routine.

The patients frequently asked who I was whilst I was on Ronda ward. They were a group of younger men fully involved and aware of their surroundings. There were also a number of patients with cancer and I did not involve myself in anything other than a superficial relationship with them. I did not experience the atmosphere on Ronda as conducive to the development of such a relationship, but also I was hesitant in getting involved with patients because of my temporary status on the ward.

The staff nurses thanked me on my last day, saying it had been good to have me as an extra pair of hands (functional); compared with Windermere who thanked me for being supportive (affective). This comment summed up the atmosphere on the ward as I experienced it. It was efficient and well organised but feelings and emotions were kept well under control.

Ronda was the only ward where I was not invited out socially with the staff.

Kinder ward

Kinder was my last ward and I felt much more confident in the research enterprise. This was reflected by the sister's comment during a social event which she made to a number of the ward staff about my research activities on the ward: 'She's very clear what she wants, this lady.'

The sister also helped me to make it clear what I wanted. She kept a 'communication' diary in which she asked me to write down when I would be on the ward (in advance) and what I would be doing. She put my research protocol in a prominent position and asked me to explain what I was doing to every nurse new to the ward.

The sister was particularly interested in the QualPacs observation schedule and asked me to give feedback to the nurses after the session. She also joined me in one session and wanted information so that she

could carry on the activity after I had left the ward.

Coffee and tea rather than meal breaks were taken with trained staff in the office. When the workload unexpectedly increased I often went with the students as there was too much work to be done to allow leisurely coffee breaks.

The period that I was on the ward was unusually busy and everyone joked that I was somehow associated with the change in workload. I was frequently told that the trained staff could not have managed without me as an extra pair of hands and I was also asked to work with students, including one whom the staff were concerned about.

I was introduced to the doctors including one of the consultants. They frequently took breaks in the office. The house officers were interested in the research but the consultant was more interested in my resemblance to the sister. He said that he could not tell us apart from a distance! This was a source of great amusement to the other staff and helped to integrate me into the life of the ward.

Some of the long term patients became very friendly with me and I felt more able to become involved with them whilst I was on the ward. I wondered if it was also a feature of their being women because I had had a similar experience with patients on Windermere ward. I had become less involved with patients on Ronda, the majority of whom were men.

Negotiation of the research role on all the wards appeared to be shaped by a number of variables: the sister's ward management style and creation of the ward atmosphere, the diagnosis and gender of the patients and my own confidence and the phase in the research enterprise.

The differences in the sisters' ward management styles, experienced through the negotiation of the research role, began to suggest their importance in shaping the nursing work according to its basic, technical and affective components. The way in which the sisters

interpreted the nursing process on their wards to organise and prioritise the work also emerged as an important area for further study.

(b) Summary of research strategy used on each ward

The research strategy on each ward differed to some extent, according to the negotiation of the research role as described above. However, the underlying strategy on each which emerged from the experiences gained in the exploratory phase of the study may be summarised as follows.

The focus of the study was the allocated students from either set A or B who started on the ward at the same time as I did. The students were allocated to the ward for a total of eight weeks (56 days). I maintained contact with the ward for two to three shifts every week of that period. The actual number of days spent on the ward collecting data varied between 17 and 21 days on each ward. Barr dependency data were collected on each of these days.

The orientation of all new students was observed. I then spent at least one shift working as a nurse with each group of students undertaking first and third year medical allocation. Contact was maintained with trained staff through 'handovers' and reports, as well as social contact with all staff including doctors at coffee and meal breaks, except on Windermere ward. The sister was interviewed using a semi-structured schedule and Pembrey's checklists of work priorities and problems.

The use of the nursing process in the organisation and delivery of nursing care and the provision of teaching and learning opportunities offered on the ward were also noted.

A QualPacs assessment was administered at the beginning, middle and end of the period on each ward. Different times of the day were observed to compare work activity on morning, afternoon and evening

shifts.

Patients were interviewed on the day prior to or the day of discharge. At least one patient a week was interviewed over the eight week period. Patients were selected when their physical and emotional state permitted.

Patient, staff and work organisation records and fieldnotes were kept as in the exploratory phase of the study.

3.4 Phase Four: Analysis of the Data

3.4.1 Analysis of data collected using qualitative strategies

Analysis of the participant observer fieldwork and interview data took place using theoretical sampling described in section 3.1, p.76, above. Thus, the evidence from which conceptual categories or their properties were generated was then used to illustrate emergent concepts (Glaser and Strauss, p.23). Analysis was also comparative in that data collected from a variety of settings (wards, classroom) and groups (students, ward sisters, tutors, patients) were used to check out whether original evidence was correct. As Glaser and Strauss observe:

Facts are replicated with comparative evidence either internally (within a study) or externally (outside) or both.

But for Glaser and Strauss the main goal of comparative analysis is to generate two kinds of theory defined as 'substantive' and 'formal'. They define substantive theory in the following way: '...that developed for a substantive, or empirical area of sociological inquiry', e.g. patient care, professional education. Formal theory is defined as that '...developed for a formal or conceptual area of sociological inquiry', e.g. socialisation, authority and power.

Substantive theory must precede formal theory, otherwise 'the consequence is often a forcing of data, as well as a neglect of relevant concepts and hypotheses that may emerge' (p.34). Thus:

The constant comparing of many groups draws the sociologist's

attention to their many similarities and differences. Considering these leads him to generate abstract categories and their properties which since they emerge from the data, will clearly be important to a theory explaining the kind of behaviour under observation. (Glaser and Strauss 1967, p.36)

It is suggested that, in order to avoid contamination of data at this early stage, the researcher should 'ignore' the existing literature relevant to the research problem. Bulmer (1983) notes the difficulty of doing this in order 'to keep one's mind altogether free from presuppositions or prior conceptualisations' in areas that have been well researched. Thus, in the present study it was impossible for the researcher to 'ignore' those areas of the literature which had been well researched and were of relevance to the research problem, such as ward learning.

Throughout the data collection and analysis the literature was regularly reviewed and used as Glaser and Strauss suggested to ascertain if any existing formal theories might aid in the generation of substantive theories from the emergent conceptual categorisations and propositions. In the present study two such theories, 'sentimental work' (Strauss et al 1982b) and 'emotional labour' (Hochschild 1983), were identified during the literature review (see chapter 2) and used in this way.

Glaser and Strauss (1967) also illustrate the potential overlap between qualitative and quantitative methods. In their view, data may be collected using a quantitative instrument but analysed in a qualitative way. For example, single items and/or indices of concepts on a questionnaire may in their view be used in bivariate analysis. In this way, 'general relationships between the items and/or indices are established which suggest hypotheses for an emerging theory' (p.190). Glaser and Strauss suggest that if relationships between variables consistently appear and can be integrated into a coherent theory, then the items and indices achieve their own validation. As with data

obtained using qualitative methods, researchers are urged to be flexible in the way they handle it to 'maintain a sensitivity to all possible theoretical relevances' (p.194). The application of Glaser and Strauss's approach to quantitative data analysis in the present study is described below in relation to the analysis of the Fretwell questionnaire.

The fieldnotes describing the content and method of classroom activities were analysed manually, as were the content of the plan of training and medical module timetables. The findings thus obtained were used as additional evidence to illustrate emergent concepts.

3.4.2 Analysis of data collected using quantitative techniques

(a) The ward learning environment questionnaires were prepared for computer analysis. A random sample of open-ended comments were analysed manually.

Fretwell's system of analysis was used. A mean score was calculated for each item by allotting scores of 5, 4, 3, 2, 1 for most to least favourable responses. A mean score for each section (A, B, C, D, E) was derived from the sum of individual item scores for that section. Overall mean scores were also calculated. These scores represented the mean of the sum of item scores 1-35. Wards were ranked on the basis of these scores.

An anxiety and stress rating for each ward was obtained by calculating a mean score from the number of times students' allotted scores of 3, 2, 1, 0 for the frequency with which they experienced these emotions on the ward. The highest rating was 3.0 (frequently experienced) to 0 (never experienced). It is possible that students had difficulties in distinguishing between the intermediate categories of 'occasionally' experienced and 'not very often'. In retrospect it may have been more appropriate to reclassify the categories as 'sometimes' and 'seldom'.

The overall ward ratings represented the students' perceptions of a ward's overall rating as a learning environment. Section scores B, C, D, and E represented a measure of the student's perception of the ward atmosphere/staff relations. Scores C and D are measures of the students' perceptions of ward teaching and the provision of learning opportunities, respectively. Item score 36 is an indicator of students' perception of stress or anxiety experienced on a ward.

Items 1-7 contained in section A of the questionnaire do not form an index of a discrete dimension of the ward learning environment. Rather they are related to individual items associated with their perceptions of the ward learning environment, such as feelings of happiness, staffing levels, workload, potential and actual learning.

Item and section scores were selected for bivariate analysis, according to whether they appeared to have theoretical relevance to the research question under study and confirm working hypotheses. Differences between wards and stage of training according to module were also examined.

Barr dependency data and QualPacs scores from the case study wards were cross referenced with relevant mean scores on the questionnaire.

Statistical methods

Comparisons of mean scores derived from the Fretwell questionnaire between pairs of wards were conducted using Gabriel's test. This is a multiple comparison procedure for unequal sized groups similar to Tukey's range test for equal sized groups (Kendall and Stuart, 1968).

Relationships between the scores on different scales across the 12 wards were tested using Pearson's correlation coefficient. As the mean score for each ward was the sum of many observations, it was possible to treat these means as continuous. Since for the testing of the null hypothesis of no relationship, only one variable need be normal and the test is fairly robust, the data were well suited to this method.

Analysis of variance was used to test whether the differences between the mean scores obtained using QualPacs on three wards were statistically significant. The statistic derived from the test is the 'F ratio', which is the ratio of the amount of variability between and within groups. Analysis of variance is used when three or more samples are to be compared and for data where interval scale measurement has been achieved, as in the case of QualPacs.

In addition, a random sample of students' responses to the open-ended questions at the end of the questionnaire were also analysed for consistent themes. These themes were used to form categories. Comments were then classified under the appropriate categories. For example, replies to question 37 on causes of stress and anxiety were classified under the following categories: nature of the work; staffing levels; staff relations; feelings about self/work/staff relations. Replies to question 38 on work and other experiences valuable to learning were classified under the following categories: nature of the work according to patient characteristics; basic, technical and affective nursing required (Goddard 1953); specialist medical knowledge, investigations and treatment; formal teaching; staff relations; effects on feelings. The inferences drawn from the replies to the open-ended questions on the questionnaire are tentative, since, with the exception of question 38, they are based on a small number of replies. The comments are used to complement data obtained from the rating sections of the questionnaire, interviews and field observations.

Theoretical rather than statistical sampling guided the analysis of quantitative as well as qualitative data collecting instruments and techniques.

As recommended by Glaser and Strauss (1967), two variable relationships were sought from the item and section questionnaire scores. The theoretical ordering and interaction between variables were

suggested by the qualitative data analysis.

(b) The Pembrey checklists of sisters' work priorities and problems were analysed manually and provided further illustrative material on the ward sister's style of management, interpretation of the nursing process and experience of common problems.

(c) The QualPacs scores were analysed manually with the aid of a pocket calculator. By calculating item and section scores it was possible to note the content of individual interactions according to psychosocial, physical and general care given and differences between shifts in terms of staffing levels and mix. The number and time distribution of the interactions given to particular patients were noted. In this way it was possible to analyse the frequency and content of the interactions which particular patients received. It was also possible to compare scores across wards.

The scores were cross referenced with Barr dependency data obtained for the same shift on each ward to see if workload, staffing levels and mix appeared to have any effect on the quality of nursing as indicated by the QualPacs scores.

(d) The Barr dependency checklist was analysed manually. Each shift for which the data had been obtained was analysed by workload, distribution of patients by age and dependency (high, medium or low) and staffing levels by number and grade. It was also possible to do a breakdown of staffing levels and mix by hour for two 24 hour periods on each ward.

The subjective impressions of the person in charge of the shift as to the status of the workload and staffing levels were used as a basis on which to select the two 24 hour periods for further breakdown. The findings were compared over time and across wards.

3.4.3 Archival material was examined in order to provide additional evidence to that obtained during participant observation, interviews and from questionnaires.

3.5 Development of Working Hypotheses from Ongoing Data Collection

The conceptual categories and hypotheses which emerged at the end of the exploratory phase of the study were used as a framework on which to build ongoing data collection and generate further conceptualisation around concepts of quality of nursing and ward learning for students at different stages of training and in different ward settings. A summary of the conceptual framework for analysis follows.

Quality of nursing and ward learning were described through an analysis of data related to the following actors and associated concepts:

Students: Unique learning trajectory, stage of training and personal life biography according to the theoretical content of student nurse training and ward allocation patterns.

Sisters: Personal management styles as indicated by the use of the nursing process for organising and prioritising patient care and the provision of student teaching and learning opportunities.

Patients: The nature of the nursing work and the learning material according to patient diagnosis, medical specialty, age, gender, race, dependency, turnover, outcome, technical and 'basic' care required.

How quality of nursing related to the ward as a learning environment in different ward settings was sought through an exploration of the following concepts: The quality of nursing already provided by permanent staff in terms of the organisation and prioritisation of the work and the provision of teaching and learning opportunities; the students' ability to give care to a range of patients in terms of stage of training, learning trajectory and personal biography.

Refinement of working hypotheses

Drawing on the concepts outlined above, the following working hypotheses were formulated for further exploration through the data as

the research progressed.

1. Quality of nursing and ward learning are favourably influenced by a management style that makes the sister and trained staff approachable and accessible to nurses and patients.
2. The way in which the sister interprets the nursing process in handling information and feedback amongst nurses and prioritising technical, basic and affective care on the ward is an indicator of how she manages the ward.
3. Sisters who are accessible and approachable are more likely to provide teaching and learning opportunities for students than those who are not. They are also more likely to meet their emotional as well as learning needs.
4. Sisters who are accessible and approachable are more likely to interpret the nursing process as a way of sharing information and giving feedback to other nurses.
5. Sisters who are accessible and approachable are more likely to use the nursing process as a way of making affective patient care visible and more likely to emphasise communication and interpersonal skills with patients.
6. Students identify technical nursing as important to patients and their learning; they also identify that technical nursing is able to be formally taught.
7. Students identify basic nursing as important to patients but only important to their learning at the beginning of training when it can be formally taught.
8. Students identify affective nursing as important to patients but do not recognise that they can be formally taught to improve their communication and interpersonal skills.
9. The quality of nursing that students are able to give is 'better' on wards where their learning and emotional needs are met by

approachable and accessible ward staff.

10. Patients judge the quality of the nursing on the emotional style in which it is given.

The research findings generated from the collection, coding and analysis of the data are presented in chapters 4-8 below.

CHAPTER 4

TEACHING AND PRACTICE IN THE CITY SCHOOL OF NURSING

Introduction

In this chapter, the content and form of student nurse training at the City school of nursing are described in terms of the theoretical content of nurse training, classroom activities, ward placements, methods of assessment, contact between school and wards, and student support systems within the school.

The findings are used to examine how far (a) they correspond with previous studies of nurse training described in the literature and (b) whether nursing ideology as presented in the City school prospectus, the official curriculum and plan of training fits the predominant ideologies of nursing promoted by nursing leaders, recommended textbooks and the General Nursing Council syllabus (GNC 1977).

These ideologies are summarised from the literature as follows: nursing concerns caring for people rather than curing diseases and emphasises the acquisition of communication skills in order to meet patients' psychological and emotional needs. The nursing process and its underlying framework of daily living activities (Henderson 1960) is a device for understanding and learning nursing. It is also a work method which prescribes patient rather than task allocation and the organisation of nursing into four steps. These steps, defined as assessment, planning, implementation and evaluation, allow nurses to prioritise care rather than cure. The extent to which these ideologies are applied in the classroom and in the ward are assessed, particularly in relation to students as emotional labourers.

The findings also address the working hypothesis that teaching in the school and patterns of ward allocation (i.e. the way in which nurse training is organised) shape students' expectations for learning on

each ward, both of which contradict predominant nursing ideologies.

The findings are derived from (a) an examination of documents such as the plan of training including learning objectives and methods of assessment and school timetables; and (b) field observations and interviews.

4.1 The Ideology of the City Hospital Nurse

4.1.1 The City school prospectus

The City hospital always sent a prospectus to people who expressed interest in nurse training, outlining the educational and personal requirements for entry and the content of training. For example, on page 1 the prospectus stated that:

It is the aim of the hospital to create a friendly and happy atmosphere in which nurses can more easily care for the physical and psychological needs of the patient and fulfil their desire to be of service to others.

On the following page, 'the three main fields of learning' were identified as:

- i. the principles and practice of nursing
- ii. the study of the human individual
- iii. the nature and cause of disease, its prevention, treatment and social aspects.

The photographs in the prospectus presented an image of a middle-class young woman who would not only acquire nursing skills and expertise, but also enjoy an active social and personal life.

In summary, the tone of the prospectus portrayed nursing as a professional training which prepared nurses to care for people and to understand the 'nature and cause of disease'.

4.1.2 The plan of training

(a) Course content and organisation

At the commencement of training, every student received a ring file containing details of the general plan of training at the City school of nursing. Information was given on the content of the curriculum, practical experience and methods of assessment. The students paid a

small fee to cover the cost of the ring file. A senior member of the teaching staff implied that this payment was a device to encourage the students to take its contents seriously.

The philosophy that underpinned the plan of training at City school of nursing was broadly stated:

Nurse Education is seen as a continuous progression of interrelated 'theory' and 'practice' with emphasis placed on the realisation of the learners' own potential.

and

The ultimate aim of nurse education is to prepare a nurse who will anticipate, recognise and meet the health needs of the individual in whatever environment nursing care takes place; thus the School of Nursing extends to wherever learning takes place. (1980, paper 1)

In the light of the literature review in chapter 2, section 2.2.1, and the question whether nurses are trained or educated, it is interesting that the term 'education' was used to describe the philosophy of a plan of training. It is also interesting that the educational principle of responding to learners' individual needs was clearly stated. The term 'education' was not used again in subsequent papers introducing the plan of training at the City school of nursing. The plan was designed to follow the requirements of the GNC training syllabus (GNC, 1977) for state registration and aimed to link 'theory' and 'practice' throughout; be modular in structure; and emphasise patient-centred care (1980, paper 2).

The course was divided into 15 modules of approximately ten weeks each, based on medical specialties. The modules aimed to give students experience in medicine, surgery, paediatrics, obstetrics, geriatrics, gynaecology and psychiatry. Students were also allocated to the operating theatre and accident and emergency departments. During the first and third years of training, there were two modules each of medicine and surgery (eight modules in all), suggesting that priority was given to students gaining experience in general/specialist medical and surgical nursing. The plan of training is presented

diagrammatically in Figure 4.1.

In accordance with the stated principle of integrating 'theory' and 'practice' throughout training, students received classroom teaching related to the medical specialties of the wards to which they were allocated. However, the balance between classroom teaching and ward practice was not equally distributed. Students received 15 weeks of school based teaching in year one, eight weeks in year two and five weeks in year three, a total of 28 weeks in all as opposed to a total of 138 weeks' of ward placements.

Paper 4 of the plan of training outlined opportunities to learn and teach in the clinical areas. Students were asked to note that 'clinical time is very short. Use every opportunity available to you. All the staff in the ward will help you, so ask' (1981, paper 4). The students were also required to obtain a minimum of four hours' teaching in each module and record it on the back of their ward objective cards.

One of the 12 teaching/learning activities presented diagrammatically in paper 4 was labelled 'Using the Nursing Process'. This was the first time the term 'nursing process' was used in the plan of training and was not linked to any underlying theoretical framework elsewhere in the text.

(b) Learning objectives and methods of assessment

Continuous assessment of students' clinical and theoretical progress was described as 'a planned series of structured and informal assessments based on detailed objectives' and 'a means by which encouragement is given to learners to reach and maintain high standards of nursing care throughout training' (1982, paper 30, researcher's emphasis).

The stated aims and/or objectives for the school based content of training were presented in a series of curriculum papers (7-14) for each module around which the plan of training was structured.

[illegible]

These aims and objectives reflected a commitment to meeting patients' physical, psychological and social needs; planning, implementing and evaluating their care; and acquiring management and teaching skills. The suggested content of the curriculum for meeting these aims and objectives was dominated by the 'natural sciences' in the foundation unit and by the signs and symptoms, techniques and procedures associated with patients with medically defined conditions in subsequent modules. The 'Nursing Process' was mentioned by name twice in weeks two and three as suggested content for the foundation unit; it arose, by implication only, elsewhere in the curriculum.

The aims and objectives for the psychiatric module (1980, paper 11) were compared by the researcher with the aims and objectives for the four medical modules (1983, paper 8) to assess if there was a difference in stated priorities. The application of the nursing process to the care of patients in a medical or psychiatric setting was referred to only implicitly, as the need 'to plan, carry out and evaluate their total and integrated care'. The psychiatric module objectives differed in that they prioritised the 'psychological and social needs' of the patient and the student's need to 'know when and where to seek expert guidance and support'.

The students were given clinical learning objectives related to wards and specialties. The general ward objectives and the learning objectives for the medical wards were examined by the researcher, following a decision to narrow the research to the study of medical modules only (3.3.3). In general, the objectives were concerned with students acquiring competence in techniques and procedures associated with the care of patients suffering from specific diseases. Relatively few objectives were identified with affective or psychosocial care. For example, out of 35 general objectives only two dealt with psychosocial needs. Objective (1) stated:

Receive and admit patients, recording the necessary particulars and caring for their clothes and property. Talk to and advise relatives. Give general and specific pre-operative care, both psychological and physical.

Objective (29) stated: 'Nurse a dying patient and care for the relatives'.

The following table summarises data obtained for the medical wards, according to specialty, total number of objectives for each and the number of objectives which were orientated to meeting patients' psychosocial needs, e.g. talking to them, giving them advice, identifying psychological and social effects of disease, death and dying.

TABLE 4.1

Ward objectives for 12 medical wards

WARD(s)	SPECIALTY	TOTAL NO. OF OBJECTIVES	NO. OF PSYCHOSOCIAL OBJECTIVES
Edale/Langdale	Endocrine & Renal Diseases	11	2
Windermere/Ullswater	Diseases of the Respiratory System	10	1
Ronda/Coniston	Gastroenterology	10	1
Kinder/Ambleside	Cardiology	8	0
Loughrigg	Neurology/ Neurosurgery	13	2
Eskdale/ Buttermere/ Wastwater	Oncology	15	2

The analysis of both the continuous assessment procedure and the criteria on which the students were judged corresponded to the learning objectives. The students were assessed on 'knowledge, skills and attitudes' although the procedure stated that the three areas were interrelated in the assessment of nursing practice. However, the principal means of testing knowledge was said to be by written work,

such as multiple choice questions, extended essays, drug quizzes and patient care studies.

The principal means of testing skills and related knowledge was said to be by practical assessment and ward reports. Attitudes were also said to be tested by ward reports and professional appraisal. Nurse teachers were designated as assessors of written work and professionalism and trained ward staff as assessors of nursing skills.

There was a formal assessment of nursing skills in nine out of fifteen modules, which included the assessment of specific procedures such as aseptic technique. In module 12, the criteria for the assessment of nursing skills were stated as 'the observation of planning and organisation of care given by the student and colleagues; the quality of care given by students and colleagues; and the written and verbal reports related to plan of care when carried out' (researcher's emphasis).

The actual format of the assessment of nursing skills was based on the nursing process framework of assessment, planning, implementation of care plan, and evaluation. However, the nursing process was not referred to by name. Criteria on which the nurse was assessed included 'personal appearance' as well as communication with patients and an awareness of cultural, spiritual, physical and psychological needs. S/he was also expected to be able to prioritise care, ensure safety at all times, record and report care given, evaluate it in terms of its effects on patients, use teaching opportunities and evaluate her own performance.

Although assessment was described as 'continuous', students were told that assessment of nursing skills should take place on a designated day and be appropriate to the student's level of training. Thus, a first warder would be assessed on the care of one patient only, whereas a third year student (module 12) was judged on her ability to

manage both patients and colleagues.

The ward report at the end of every allocation judged students on similar criteria to the practical assessments, which included 'aptitude for this field of nursing'. In other words, students' skills were judged on the basis of the ward specialty.

They were also judged on women's traditional attributes, such as appearance, punctuality, observation, forethought and identification of priorities. Appearance was one of the criteria on which candidates were selected to become flight attendants, and was seen by employers as a prerequisite for the 'good' emotional labourer (Hochschild 1983). Ungerson (1983b) included punctuality, time management and high levels of social skills in her list of women's attributes.

In summary, two strands emerged from this analysis of the prospectus and plan of training. First, they were similar in some respects to the predominant ideologies promoted by nurse leaders and educators described in chapter 2, section 2.1.1. However, the the nursing process was not used in the plan of training as a device for understanding and learning nursing, and remained overshadowed by a disease orientated, technical approach to nursing. This domination was evident in the plan of training, which was organised around modules based on medical rather than nursing criteria. The organisation of nurse training based on medical specialties was similar to that described by Roper (1975). However, nursing principles and the nursing process framework were the stated criteria on which students' nursing skills were assessed.

Secondly, the prospectus and plan of training contributed to a local nursing ideology at the City hospital that presented nurses as caring, professional and at the service of others. This was reflected in the terminology used to describe the qualities required of people to nurse at City hospital and the philosophy that underpinned the plan of training, practical assessments, and professional appraisals, which

encouraged students to 'maintain high standards of nursing' throughout training. Regular assessment based on an ideology aimed at maintaining high standards of nursing could be interpreted as the means by which students were indirectly supervised to do emotional as well as technical and physical labour, as defined by Hochschild (1983).

4.2 Teaching and Learning to Nurse at the City School of Nursing

The following accounts of teaching and learning to nurse are based on field observations and interviews. They are used to describe how students, nurse teachers and one ward sister experienced the overall organisation of nurse training at City hospital, to look at the teaching and learning of nursing in classroom or ward, and to examine how far their accounts reflected national and local nursing ideology. 'Theory' is used when describing examples of knowledge as taught in the school of nursing. 'Practice' is used to describe examples of what was done on the wards.

4.2.1 The organisation of nurse training at City hospital

The students' plan of training stated that the City school 'extends to wherever learning takes place'. Data were used to examine this statement further. When nurses referred to 'the school' they used it to describe the building in which nurse training was organised and the teachers who were responsible for carrying it out. The 'school' was seen to serve two main functions, providing the 'theoretical' content of nurse training and administering the formal training requirements, i.e. ward learning objectives and student assessment.

A senior tutor, when asked about the school's role, replied in terms of her own role:

Ideally what you are trying to do is give the students enough information to allow them to learn from the ward situation.

Students at the beginning of training and the senior tutor shared similar views of the school's role. But as the following quotations

demonstrate, the students' views changed during training:

The school gives a good basis for what you learn on the wards. It's easier to learn if you've got the basis.

and:

I quite like being back in school (after eight weeks on the ward). It's different from the wards (where) you pick up so many bits of information ... You can understand things a lot better (after being in school) and make a bit of sense about what's going on. (Students on their first ward allocation.)

By the time students had reached the end of their second ward they were already beginning to doubt the relevance of school based training to their ward practice. Third warder:

When we first went to the ward (from the school) we were expecting it to tie in together, but I find I learn most things on the ward.

Fourth warder:

The first few times when you go into school you are learning new things. Then you gradually regard it as a waste of time. You'd rather be on the wards.

Fourth warder:

I've hardly learnt anything from the school. We aren't well taught. It's completely confused and old fashioned.

These students also referred to the views expressed by third year students with whom they had worked. Third warder:

It's a really controversial thing because all the third years say 'Oh, school has got nothing to do with nursing'.

Fourth warder:

The third years regard going into school as rather a waste of time.

These views were confirmed during interview with third year students:

The school is just a joke!

The time in school, you know, you don't really feel you learn anything.

At the time, lectures seem interesting but when I look back I can't really think of a thing I learnt in school.

Why did students identify with the wards rather than the school? Most of their training (138 weeks) was spent on the wards and only 28 weeks in the school. Their teachers were located in an institution

which was administratively and geographically separate from the the wards. The students rarely saw their teachers on the wards and so only associated them with formal classroom teaching and the administration of nurse training rather than its practice.

Officially, there was a system of tutor-ward liaison. Every tutor was allocated to at least one ward, where they were expected to liaise between the ward staff, students and school. In addition, a team of clinical teachers was employed to work with students on the wards. During the period of data collection, the majority of the clinical teachers left for various reasons. The one who remained described the difficulties of her role thus:

As a clinical teacher you fall in between the service and the school side. School tends to see you as a junior tutor so they give you all the hassle to do, all the non-status jobs, in a sense. The service side see you ... as below them (sisters) if anything ... and they sometimes see you as an interfering old busybody.

She said she was unable to have contact with more than three wards. Some tutors maintained links with wards by organising weekly tutorials for students. However, according to the majority of tutors, tutor-ward liaison was limited, because of the demands of classroom teaching:

From the tutor's point of view it's like a sausage machine, you know. Every week we have one or two groups. We just see lots of groups. You don't even get to know the students properly. They spend 28 weeks in school out of their three year training and if you multiply that by 15 groups you have always got one in school ... Not only that. I am supposed to be liaising with two wards ... I haven't been there for five weeks because I didn't have the time to go there.

The sharp distinction and lack of integration between school and ward was confirmed by others:

They (the teachers) came nowhere near me. The school don't have enough to do with you on the wards. It's two different worlds. (First year student at the end of her third ward allocation.)

A tutor saw the teaching and learning of nursing in classroom and ward as two distinct activities. She was doubtful whether school and ward could work together:

I don't know that we can (work together) really because I think if we are not careful what we will lose is what we have fought for for a long time, which is time out for student nurses in school, where theoretical learning can take place uninterrupted. There are only some things which can be learnt in that sort of environment which cannot be taught on the ward.

One ward sister is quoted here because of the insights she gave into the separation between school and ward:

The students manipulate the school of nursing against the ward. They say one thing to the ward and another to the school. They come from block and say 'we didn't learn anything; it was dreadful'. It happens here on the ward. When pressed the students say 'well, we learned practically'. It's a problem because tutors say 'well, the students don't realise they are learning'. I just wonder how far you can go on saying that ... the students will only learn more if they realise that what they are doing is learning.

Thus, the students were seen to be able to manipulate the school against the ward because the two were distinct and separate worlds.

The tutors' and the sister's observations suggest that students and teachers believed that formal teaching was required in order to ensure learning. Another tutor's comment reflected a similar finding:

The girls ... don't recognise the wards as learning areas. I have asked them this very specifically. It's very much so, as far as they are concerned. By and large they think the school is where they learn. And they are very frustrated that what they learn in school they are not allowed to practice in the wards.

This latter quotation illustrates the co-existence of two contradictory views. On the one hand, the majority of students reported that they identified the wards rather than the school as the place of learning. On the other, the predominant paradigm that associated formal teaching with learning, both of which were associated with the school, also led students to identify the school rather than the wards as the 'learning area'.

In summary, the way in which training was organised at the City school of nursing divided the school and the wards into two separate and distinct worlds. The tutorial staff were seen as synonymous with the school. The characterisation of ward and school as two separate and distinct worlds supports findings reported by Dodd (1973), Melia (1981)

and Gott (1984).

The modular scheme of training meant that there was a continuous throughput of students in the school. Hence, tutors reported that they did not have sufficient time to go to the wards, despite an official system of tutor-ward liaison. At most they were able to organise weekly ward tutorials.

The predominant teaching/learning paradigm amongst students and tutorial staff was based on a presupposition that formal teaching and theoretical knowledge were necessary to ensure learning took place. Even though the wards where the students spent the majority of their training were frequently identified as the major place of learning, they also viewed the school as the 'learning area'.

Students' views of the school as a place of learning appeared to change and become less positive as they progressed through training.

The identification of formal teaching as important for learning was also found in a study of the ward learning environment by Fretwell (1982). The findings confirm that the statement in the plan of training that City school 'extends to wherever learning takes place' was not a view shared by students and tutors.

4.2.2 The theoretical content of nurse training at City school of nursing

One of the criteria on which students were selected for training at City school of nursing was academic ability. The academic qualifications of five sets of first and third year students involved in interviews, discussions and non-participant observation in the school showed a predominance of science rather than arts and social science qualifications. These findings reflect the selection criteria set by the senior teaching staff of the school of nursing, i.e. five 'O' level passes in the General Certificate of Education, to include a science subject, mathematics and English, obtained all at one sitting at grade 'B' or above. Evidence of 'A' level study was also viewed

favourably. The national requirement at that time was only two 'O' level passes and was therefore much lower than at the City school.

The number of subjects obtained by the five sets of students at 'O' level ranged from an average of 6.5 to 9.0 and at 'A' level from an average of 1.4 to 1.9. Seven of the 126 students were graduates. In one third year set picked at random, nearly 100 per cent of students had obtained an 'O' level pass in biology. This tendency was evident in the other four sets of students. A third of the set had also obtained an 'A' level pass in biology. Thus, a 'significant' number of students, had obtained 'O' and 'A' level passes in biology as a pre-requisite for nurse training, suggesting that the theoretical basis of nursing was biological.

The following comments show that students considered biology to underpin the theoretical content of the Foundation Unit (FU). The students were more likely to value the FU if they did not have 'A' level biology. A student who had read for an arts degree found the FU useful, 'but not if you have 'A' level biology'. Another student recollected that she had 'found it quite hard at the beginning' as she did not have 'A' level biology. During participant observation on Windermere ward a student said she felt that, because she did not have 'O' or 'A' level biology, she did not have enough 'theory' to understand what was going on in the ward (see chapter 8, section 8.2.2). She also added that unlike the rest of her set who had studied 'O' or 'A' level biology she was not bored by the FU.

Another first ward student who had 'O' rather than 'A' level biology was less critical of the FU than her colleagues. She said:

A lot of people said when we were in FU that it was really common sense ... but there's a lot of stuff that I wouldn't think of as common sense.

Students with 'A' level biology judged the FU in less favourable terms, since they felt they were repeating knowledge that they already knew,

and which was sometimes of an inferior quality. A first year student who had studied 'A' level zoology recalled a 'lesson' when the tutor referred to 'tummy' instead of stomach or abdomen: 'I don't know what she meant. I almost walked out.'

Overall, students doubted the relevance of the FU after being on the wards, irrespective of the level of their biology qualifications:

It was very biology orientated. I thought it would be all practical, which would have been more beneficial ... the practicals were the most useful sessions.

And another:

You learn 'A' level stuff in school and a bit about lifting but you never remember it.

The FU was described by yet another first warder as 'all cells and bits that don't connect with the patient'.

Students at the beginning of training frequently described nursing knowledge in terms of the 'basics', i.e. bed-making, bathing, mouthcare, lifting, feeding, toileting, talking and empathy with patients. In other words, the students identified the activities of daily living as a framework for learning.

The conceptualisation of nursing as care and people work was mentioned by only two students, both in the first six months of training. One student said about the content of classroom teaching:

Nothing is really said about care. They (the tutors) say you have to care but nobody actually says what caring is.

Another student said:

School's got potential. Nursing isn't a dry boring subject ... we are talking about people.

The first year students also articulated the need for 'any theory of nursing to be intimately related to practice' (McFarlane 1977). For example, a student during her first ward allocation said:

Theory is being shown how to do things practically on your first ward, all the basic jobs.

Another first warder said:

I find I learn most things on the wards, even my theory, because you can equate it to the patient.

A first year student on an oncology ward observed:

Theory on its own is no good, practical stuff on its own is no good. But if you can use what you have been told and see what people are going through, I think that's a good idea. It's the interpretation of what you see.

During discussion after six months of training, students reached the following conclusions:

You know the basics by now. You need to know more about different techniques, investigations, things that are done on the ward, like drains and how they work and naso-gastric feeds, suction, stuff like that you haven't done before.

and:

Theory is the solid facts, the diseases, the anatomy and physiology. Practice is the procedures and seeing how it (theory) relates to the patient.

The students' comments were indicative of a shift in emphasis during the first year away from so-called 'basics' to the 'solid facts' of 'theory' and the techniques and procedures of practice.

A comment made by a third year student illustrated an ongoing commitment to learning about 'facts' and the importance of biological knowledge when she said:

I am a third of the way through my third year and I don't know a massive amount.

Q. How do you know?

I did biology up to 'A' level so I do know how much I should know.

Q. What about the school's role ?

I want higher knowledge as well as the interesting educational skills like videos ... worksheets and discussions. That is helpful and will help me to become a nurse ... but they (the tutors) seem to work on the basis that I have done a massive amount of work on my own ... somewhere the absolute facts are being missed out.

The student was using 'A' level biology as a yardstick by which to measure the knowledge and 'absolute facts' that she believed she needed to become a qualified nurse. Two other third year students expressed similar doubts about the state of their knowledge because they judged

it on the basis of its medical and technical content.

Although you spend a lot of time building up your nursing skills I think the depth of knowledge into disease, drugs and therapy gets rather left by the wayside and I find that my knowledge is really sort of patchy and scanty and there is no sort of depth to it. I've just learnt bits here and there.

I'm very aware of how fragmented our knowledge is, how we're thought of as general nurses ... we know a little bit about the odd wards we've worked on but I've not done any cardiology or seen an appendicectomy.

Tutors were aware of the students' 'theoretical' preferences. One tutor characterised these preferences in words which accurately summarised the students' views:

First years want a lot of very basic information, how to blanket bath, straightforward basics, and you can get away with being a lot more creative ... in terms of teaching methods. The third years want information for state finals and they want it in the most economical and best way they can get it - lectures followed by worksheets - straight solid information that they can write down on their paper ... how do you nurse this and that and how do you cope looking after traction. Yet in the back of your mind you feel it is not as educational as it could be.

During interview tutors demonstrated an understanding of the predominant nursing ideologies which emphasised caring for people using the nursing process rather than curing disease. Only one tutor admitted she was uncertain about the approach:

I do like the medical model and it can be nice and logical and it's scientific and you can do that in school beautifully. I don't think we can throw the medical model out completely because at the end of the day we have got people coming in (to hospital) with diseases.

She then described what she saw as a nursing model:

I think the model becomes a bit pedantic. It's another checklist against which to tick off your knowledge or hang your concepts on. We have gone overboard thinking it's the person we must look at.

The tutor concluded that:

Nurse tutors are having difficulties using the nursing model. We haven't been sufficiently prepared.

To her, the nursing process was about feelings and attitudes and more applicable to the ward.

Another tutor who described herself as 'pro nursing process' described colleagues whose teaching was still 'very task orientated and based on the medical model'. Yet another tutor thought that tutorial staff were 'not good at equipping students with communication and interviewing skills which are fundamental to the nursing process'.

Indeed, students did not identify the nursing process as part of the theoretical content of their training. At best, they were able to conceptualise it as a work method based on ward experiences rather than on classroom abstractions.

When one first warder was asked 'did you learn about the nursing process in school?' she said:

We did a bit, but I don't think we realised how important it was. We didn't do a care plan until our last day in school, but if they (the tutors) had tied it up with the nursing process you would have realised that the two went together. But I didn't realise until then that that was the nursing process and that was what you did with it.

The same student was still having difficulty in describing the nursing process conceptually at the end of her third ward. After some thought she defined it as 'what you do, really'.

Another first warder, quoted above, who clearly identified a need to learn how to care for patients, as opposed to medically orientated knowledge, 'forgot' to refer to the nursing process whilst answering a timed essay in class. A third ward student assessed the nursing process as 'such a waffly subject ... it all boils down to common sense in the end'. Even though students at the beginning of training identified living activities, care and people as part of nursing knowledge, they did not associate them with the conceptual base of the nursing process. One reason for this was that the tutors did not help the students to identify the theoretical framework underpinning the nursing process.

Third year students had a view of the nursing process from their ward practice and described it in the following way:

I would say it (the nursing process) is patient allocation as

opposed to work allocation ... It's more thinking of the patient as a whole as opposed to one nurse being responsible for bed pans etc.

Another much quoted example was the use of the nursing process for obtaining written information about patients' technical care, as the following quotation illustrates:

The nursing process is useful on surgical wards for telling you what dressings patients need and what to clean wounds with etc., or on wards where the verbal reporting isn't very good.

Although the tutors were more able to conceptualise nursing in terms of activities of daily living and the nursing process than were the students, they were still reluctant to dispense with the so-called medical model. They also felt subject to organisational constraints on the content of their teaching at both a national and a local level.

For example, the curriculum was based on a syllabus external to City school (i.e. the GNC) which was mentioned by two tutors. One confirmed that 'we teach the nursing process because it's in the syllabus'. The second tutor mentioned that it was not possible to change the local curriculum unless it followed the syllabus. Other tutors described themselves as feeling that they were part of a greater order, namely a member of a team under the direction of a senior tutor. This administrative arrangement seemed to reduce their control over the content and method of their teaching. A recently qualified teacher said:

As a new teacher you tend to think that this curriculum is not really very much to do with you and all you are concerned about are the few sessions you organise.

Another more experienced tutor was also subject to the control of a senior tutor. She articulated the problem in the following way:

I'm a jack of all trades and a master of none. I teach 22 different subjects. Microbiology; they don't ask if I have a microbiology degree. They ask you to teach pharmacology. What do I know about pharmaceuticals? - All sorts of things.

This tutor was describing not only the subject areas that the content of the plan of training covered (i.e. medically orientated) but also

the dilemma of the nurse teacher as generalist rather than specialist, who lacked control over the topics she taught and consequently did not teach nursing. As described in section 4.2.4 below, the students were likely to be critical of their teachers under such conditions.

The tutors' reluctance in dispensing with the medical model and feelings of constraint were reflected in the content of their teaching of the first and third year student groups, observed by the researcher. A content analysis of the foundation unit and medical module timetables for the two groups demonstrated that preference was given to sessions associated with biological science, medical specialties and technical procedures. As shown in table 4.2, sessions associated with the nursing process and its framework of activities of living, communication and affective/psychosocial care were much fewer.

In summary, the findings confirm that the students had a limited understanding of the nursing process and its underlying framework of living activities, communication and affective/psychological patient care.

Even though the nursing process was represented in the language of the plan of training, it had not been adopted by either students or tutors as a viable 'theoretical' alternative to the 'medical model'.

TABLE 4.2

Analysis of foundation unit and medical module timetables
according to categories of sessions

CATEGORY OF SESSION	MODULE:										PER CENT OF TOTAL
	FU	M1	M1	M3	M3	12	13	14	15	TOTAL	
<hr/>											
MEDICAL SPECIALTY:											
any session with reference to medical specialty, specific disease	1	6	6	4	8	10	7	7	7	56	23%
BIOLOGICAL SCIENCE:											
anatomy,physiology, pathology, nutrition, pharmacology	31	3	1	6	5	3	2	4	4	59	24%

CATEGORY OF SESSION	MODULE:										TOTAL	PER CENT OF TOTAL
	FU	M1	M1	M3	M3	12	13	14	15			
<hr/>												
TECHNICAL PROCEDURES: e.g. radiotherapy, X- ray and ultrasound	6	3	1	2	1	0	0	0	1	14	6%	
NURSING PROCEDURES: e.g. bedbaths, mouthcare, patient handling	23	14	1	0	0	1	0	1	2	42	18%	
AFFECTIVE/PSYCHO- SOCIAL NURSING: e.g. listening and interviewing skills, discussion of critical inci- dents, patients in pain, death, dying, perceptions of patients behaviour	5	1	3	4	3	4*	2	2	0	24	10%	
ACTIVITIES OF DAILY LIVING & FUNCTIONAL DISORDERS: e.g. assisting patients with ADLs; rehab- ilitation, care of unconscious/ dyspnoeic patients	2	3	1	0	0	1	0	0	1	8	8%	
NURSING PROCESS	1	1	0	0	0	0	0	0	0	2	1%	
WARD-SCHOOL INTERFACE: e.g. discussion of ward experiences	11	2	1	0	2	1	0	0	0	17	7%	
Guided study (work sheets, library)	5	3	0	0	0	0	1	0	3	12	5%	
Individual study	3	0	0	0	0	1	1	1	0	6	3%	
<hr/>												
TOTAL											240	100%

* Plus additional sessions in an oncology study day.

4.2.3 The interface between 'theory' and 'practice' at the City school of nursing

Examples of the interface between 'theory' and 'practice' at the City school of nursing are described, in order to seek explanations for

the discontinuities between and integration of the two.

The knowledge that students believed they needed and tutors gave them was dominated by biological sciences, medical specialties and technical procedures. A tutor felt that there was 'a great gap in our knowledge about the students' ward experience' which prevented the successful integration of 'theory' and practice. She gave two specific examples; the first example referred to medical module 1, about which she said:

I have heard some of the clinical teachers say that the students on their first ward don't really have any idea of their role.

As the following comments made by first ward students suggest, they were unable to identify a clear role for the school in preparing them for their first ward experience. About the foundation unit preparation, two first warders agreed that 'whatever you had done (in the school), it would still be just as big a shock when you actually got here'. Another student said: 'I don't think there is any way you can prepare for the ward'.

The tutor's second example referred to surgical model 2, and offers further explanations for why students failed to identify with the school in preparing them for the wards:

In their first surgical wards I know they have problems adjusting. We probably don't prepare them enough.

She felt that the inadequate preparation was because of insufficient feedback from students and ward staff as to what they saw was required from tutors to prepare students for the wards. A student at the end of her third module confirmed this view:

The ward staff should be much more involved in the school. They are a bit like us; they think the school of nursing (and the ward) are almost contradictory ... they (the school) don't really know what's done and not done.

Students also gave examples of knowledge which they had gained from the school and valued, but were unable to apply in the wards. These examples help to explain why students did not always identify the wards

as 'learning areas'. For example lifting, as taught in the school of nursing and practised on the ward, was frequently cited as problematic. Three students expressed discomfort at the idea promoted by tutors that they should refuse to lift patients with staff who were using faulty technique. One student described her recent experience on a medical ward (third module):

They just do the 'drag'* and it's really difficult to say 'I think we should do the 'Australian'.* Tutors should understand how difficult it is for a first warder telling senior staff the correct procedures.

Students in their fourth module were still expressing similar views. Hierarchical relationships rather than inaccurate knowledge were identified as an obstacle to integrating 'theory' with 'practice'. The difficulties experienced by students in practising what they had been taught in the school as the 'right way', and the lack of support by tutors to resolve sources of conflict in the ward, confirms findings reported by Gott (1984).

Students did, however, appreciate the difficulties tutors encountered in preparing them for ward experiences. One of the main difficulties they identified was the fact that there were 12 medical and 12 surgical wards to which 20-30 students, in groups of one to three, were allocated at any one time. Students spent one week in school prior to going to those wards. This was seen as insufficient time to prepare all students for all wards, given the range of specialisms.

However, the 'theoretical' content of classroom activities did not always correspond in the students' eyes to the learning material on their allocated wards. For example, the content of the school

* 'Drag' was the name used by students to describe faulty patient handling techniques. 'Australian' was the name of the lift recommended for use by nurse teachers.

preparation and consolidation weeks in medical module 3 was concerned with the care of oncological patients. Sessions included the pathology, medical treatment and nursing care of patients suffering from malignancies. It also included sessions on care of the dying and their relatives. Students allocated to oncology wards found the school weeks helpful. Those allocated to other medical wards did not. The students could only interpret the theoretical content of the sessions in terms of the medical specialty of the wards where they were allocated. Students on two wards where the researcher was undertaking participant observation complained that 'the school week had nothing to do with the ward'.

The wards Edale (endocrinology) and Ronda (gastroenterology) both had at least two patients suffering from malignancies at the time; indeed, a third year student interviewed following allocation to Ronda ward concluded:

I wouldn't mind staffing there. I've always found some satisfaction in nursing oncology patients.

It appeared that the senior student, unlike students in their first year, was able to see beyond the nominal specialty to other underlying patient problems. The influence of medical specialties in determining the nature of the nursing work and how students defined the ward learning environment is discussed further in Chapter 5.

Students gave the following examples of well integrated 'theory' and 'practice'. One example related to the quality of the theoretical content of classroom based activity and its apparent relevance to practice, such as the oncology day. Third year student (module 12):

We were worried for so long what a waste of time school was but last week was really useful and taught me a lot ... I don't know whether it was because I was interested in the subjects, but the oncology day was the first time we'd had a day like that with the multidisciplinary teams.

A student at the end of training still remembered the oncology day as having brought 'theory' and 'practice' together. She also mentioned the

importance of it being 'multidisciplinary' in that nurses, doctors, social workers and pharmacists taught as a team. Her conclusion was 'If it (school) had been more like that, we would have got more out of it'.

Another example related to being given theoretical knowledge in the clinical area, both by tutorial and ward staff. A third year student said:

I think that some of the medical and surgical wards don't get down to teach you as well as the specialties do (paediatrics, geriatrics, psychiatry, obstetrics). They make an effort because they know they're different and they know that perhaps your knowledge isn't that good and they make an extra effort.

A third example of well integrated 'theory' and 'practice' referred to a specialist multidisciplinary geriatric programme. A third year student at the end of training, who identified this programme as an example of well integrated 'theory' and 'practice', explained why:

I think it gave you a wider view. You saw potential. We visited various hospitals and saw old people's homes. It gave you ideas for planning aftercare of patients and alternatives for improving the quality of their lives.

The multidisciplinary approach of the oncology day and geriatric course was an important feature of their theoretical and practical relevance, in the students' eyes. One unique example of 'theory' being applied in 'practice' was told to the researcher by a first ward student. She had been allocated by a staff nurse to look after a patient who had an underwater seal chest drain. While she was alone with the patient, the drainage tube became disconnected. She had not received instruction on what to do but a pair of Spencer Wells' forceps had been provided to clamp the tube. The student acted promptly, drawing on her knowledge of the anatomy and physiology of respiration. She worked out that she must clamp the tube to prevent air entering the patient's lung and causing a pneumothorax.

This vignette supports the rationale for teaching students sound

biological fact. It is interesting, however, that the student said that she referred to knowledge acquired during study for 'A' level biology rather than knowledge acquired during the foundation unit.

In summary, the above accounts demonstrated the complexity of the 'theory-practice' interface. They also demonstrated that the 'theory-practice' conflict arose for a number of reasons. The content of classes was not generated from the reality of ward practice and so led students to question its relevance. Students were not supported and taught how to apply knowledge in the ward.

The most successful integration of 'theory' and 'practice' appeared to be when ward and tutorial staff were seen both to have specialist knowledge and to apply and teach that knowledge on the ward.

4.2.4 Teachers and their methods

There was a general complaint amongst students that tutors did not pitch either content or method of teaching to the appropriate level. A first year student complained that:

Instead of them teaching us from the top down they're teaching us from the bottom all the time.

A student about to take state finals also felt that the level of knowledge taught in the school remained the same throughout training:

You are not being pushed to your limits as you go on up further through the school ... the level of input remains the same.

Students liked lectures to be concise and to the point. One fourth year student articulated the problem in the following way:

You are learning by repetition. Teachers take a week to teach you what you could do in a day.

In other words, students wanted expert theoretical knowledge from their teachers, presented in a concise didactic manner. Since they identified medical knowledge as their theoretical frame of reference, they not surprisingly thought that the theoretical content of their training would improve if they had more lectures from doctors. A first year student thought that doctors 'are much more concise and to the point

than tutors'. Another student at the end of training stated:

Students should only be taught by people who know what they are talking about. Therefore there should be more doctors' lectures.

The last week in school (module 15) was consistently identified as 'one of the best weeks we've had'. Reasons given were that lectures were optional, short, to the point, and geared towards preparing for state final examinations.

A student who was a university graduate was puzzled by compulsory lectures because 'at university it was up to you to make up lectures if you missed out'. Some tutors also expressed dismay at this, especially as the lectures were organised within a very full teaching programme.

First year tutor:

I don't think we should have this rigid timetable. I negotiate with the students, but we have to account for every hour they are here.

The tutors also felt that they were limited in the amount of educational rather than training techniques they were obliged to use. One tutor preferred the notion of being a 'facilitator' rather than teacher. Another teacher was frustrated by 'the rigidity of other teachers' attitudes within the school':

I think that's a great shame. I reckon that education should be rather more broad thinking.

The most senior member of the teaching staff described the tutors' dual role in relation to disciplinary procedures and student assessment. She thought it might explain:

Why teachers still teach hierarchically - "them and us". They have a disciplinary as well as a teaching role. They are the (students') judge and jury. It is very difficult to fill this role.

The only male interviewee, a history graduate, was also aware of the contradictions in the tutors' role, but he attributed the rigidity to the fact that students were paid rather than being 'true' students, even during school weeks. Therefore they were 'paid' to attend lectures as well as be on the wards:

School retains a hierarchical structure which does not fit in easily with its ethos ... tutors try for a more egalitarian relationship but the problem is we're getting paid.

He also felt that tutors tended to treat students in 'too childlike a manner rather than as colleagues'.

The majority of students referred to the feeling of being treated like children in the school, not only in terms of the low level of knowledge but also the nature of their relationship with the tutors as one of 'them and us'. Discussion with students at the beginning of module 3 yielded the following comment:

It's difficult to be treated how we are in school (like babies) and then go to the wards, where you are expected to know what you are talking about.

Student about to take final examination:

Some of the tutors tend to treat you like school kids and you don't want that. I mean nobody wants to be spoken to like school kids, because you left school a few years ago.

Thus, teaching methods and tutor-student relationships appeared to be hierarchical and bureaucratic, a finding also reported by Gott (1984).

Students were expected by many tutors to take responsibility for their own learning. However, the timetables showed little time for private study (table 4.2). One student who was a university graduate expressed frustration at having insufficient time to do the reading he wanted, when he wanted.

A tutor who had come from another school of nursing was surprised to find that at City:

... within the classroom there is this resistance to any sort of individualised learning, any independent learning where they go off and they find out something ...

One of the sources of frustration for students was that they were receiving contradictory messages. On the one hand they felt they were being treated like children; on the other they were being expected to take responsibility for their own learning both in the classroom and on the ward.

In summary, the teachers expressed a commitment to more open relationships with students and a more flexible approach to teaching, in line with educational principles. But, in practice, students experienced their relationships with their teachers as hierarchical and the content and methods of teaching as rigid. The students also felt that doctors rather than nurses should be teaching them medical specialist subjects. These views reflect the predominant teaching/learning paradigm in use, the limitations imposed by the bureaucratic organisation of nurse training on teaching and learning and the lack of commitment on the part of some tutors to a more individualised approach to teaching and practice of nursing.

4.3 Learning to do emotional labour: selection, training, supervision and support

The final section of this chapter aims to examine the extent to which students in the City school of nursing were selected, trained, supervised and supported to do emotional labour (Hochschild 1983).

4.3.1 Selection

The selection and recruitment of students to the City school, based on academic criteria, was discussed in section 4.2.2. The content of the prospectus as promoting the image of a caring, young woman who wanted to be of service to others suggested other criteria for selection. Like Hochschild's applicant to become a flight attendant, the prospective nurse was 'introduced to the rules of the game' through the language of the job prospectus, even before interview. Applicants to City hospital were also expected to have been engaged in paid or voluntary work with people. The Assistant Director of Nurse Education (ADNE) thought that 'some form of community work with deprived groups' allowed the students 'to put their toe in the water'. Indeed, 'any job with the general public' was acceptable in the ADNE's opinion since the students were able to learn that 'not everyone is nice'. Thus, nursing was seen as a 'people job' by recruiters and students before they even

began training. As one student observed:

When you come for your interview, they ask you if you're interested in people, do you like talking to people, do they matter? If people don't matter then you can't do nursing.

The ADNE also stated that 'middle class' candidates were preferred, because they would be working 'among professional staff' on the wards. She explained that although there were no 'exclusion criteria' few applicants from ethnic minorities applied and even fewer were 'suitable' for selection, because students needed to come from backgrounds that enabled them to 'stand up in that sort of environment' (i.e. professional). The ADNE concluded:

We are trying to match people to this environment. It is friendly ... very hierarchical and academically demanding'.

Another member of the teaching staff characterised the students as from 'very privileged homes, comfortable, safe, secure and supportive'.

At the beginning of the study period, there was no shortage of applicants. Records showed that 3,500 candidates might apply for nurse training annually, but only 1,600 would be interviewed. Only since 1978 had the school officially recruited men. They were poorly represented as a group, and numbered as few as ten at the time of the study.

The annual vacancies for students were 180 in 1981/82, 150 in 1983 and 120 in 1984/85. The reason for the decrease was government pressure to reduce spending and the proposed amalgamation of the City and neighbouring County schools of nursing.

The majority of students were white and female and, together with their middle-classness, corresponded with Hochschild's characterisation of middle class women as more likely to do emotional labour management in the home as well as in the workplace because of the way in which they had been socialised to deal in and with feelings. Many of the students had been privately educated. They were charming, polite and appeared outwardly calm and in control. They spoke and behaved 'well'.

It appeared therefore that applicants were more likely to be selected to train at the City school of nursing if they were middle class, female and privately educated, and demonstrated an interest in working with people.

Patients remarked on these characteristics (see chapter 6, section 6.2), including a student who had been a patient at City hospital shortly before commencing training:

I was a patient before I began training and I thought then all the girls seemed the same, very much a type and fairly upper class.

City hospital was a former voluntary hospital and as such still maintained the tradition of recruiting nurses who tended to be middle class, female and white, as described by Abel-Smith (1960) and Bellaby and Oriabor (1980).

4.3.2 Training

Table 4.1 showed that the timetables were heavily dominated by medical specialties and biological science. Affective/psychosocial nursing (communication skills, activities of daily living) and the nursing process accounted for only 14 per cent of sessions.

It was noted that the formal training of students to do emotional labour was most likely to occur during those sessions categorised as affective/psychosocial nursing. For example, non-participant observation in the classroom yielded the following insights based on accounts of two such sessions. The sessions were chosen because they represented attempts to train students to do emotional labour. In the foundation unit, sessions were given by the psychiatric tutor, who was invited by the general tutors to teach 'listening and interviewing skills'. He followed this up at the end of the first ward allocation with a session on 'perception of patients' behaviour in hospital'. It may be inferred that, because the psychiatric rather than the general tutor was conducting these sessions, they were immediately set apart as 'different', requiring expertise that psychiatric nurses were more

likely to have than general nurses.

The session observed by the researcher was a lively discussion on nurse perceptions of patient behaviour. Perception was defined by the tutor with assistance from students as 'the interpretation and judgements made by nurses through observation of the way patients behave'. The role and context in which this behaviour took place and the associated concepts of stereotyping and prejudice were discussed.

Extracts from the discussion relevant to training nurses to do emotional labour are presented below.

T. What stereotypes do patients have of nurses?

S. Angel. S. Beautiful. S. Florence Nightingale.

S. They don't know how to react to you in your own clothes, when you go into the ward on your day off.

S. It's the same with you when you see the patient in their own clothes.

T. Why is that?

S. Role? Uniform?

T. It's both role and context which determine how you see patients' behaviour. Does Mrs (refers to a senior member of the school staff) still have that thing that you should smile the whole time?

S. Yes, she still has it.

T. ... No wonder patients are confused.

S. It's dangerous the authority nurses have over patients.

T. What sort of things interfere with our perceptions of patients?

S. Prejudice.

A discussion of handover reports on the wards followed, in which students observed how comments were made about patients which affected how nurses perceived them. For example:

S. Some patients become 'pets'. We all do it. They're looked at as 'very nice'. Or other patients get the reputation of being an 'old sod' and then you think 'well, sister should know her work. If that's her opinion I'd better avoid him'.

S. Often you find that it's not true what they (trained staff) tell you.

S. We as beginners are very vulnerable and on the side of the

patient. Staff nurses have seen it all before and think patients are up to their 'old tricks'.

The content of this session was interesting in terms of its association with learning to do emotional labour. Students referred to the labels that patients and nurses attached to each other. Nurses were 'angel, beautiful, Florence Nightingale' which to the students implied that the patients did not see them as 'people'. Both nurses and patients were cast in a 'role'. Part of the nurse's role according to a senior member of the school staff was to 'smile'. The imagery conveyed by the students and the tutor during their discussion was reminiscent of the terms used by Hochschild to describe emotional labour in the airline industry. Flight attendants were also encouraged to smile by their trainers.

Differences between the two groups of workers (nurses and flight attendants) became apparent, however, as the students described the 'authority' that they felt over patients. The hierarchical relationships within the health care system allowed nurses to withdraw emotional labour. Nurses at the beginning of training saw themselves as vulnerable and on the side of the patient. Patients could acquire either positive or negative labels. Those patients who acquired a negative label which was then reinforced by the ward sister gave students legitimisation for withdrawing emotional labour by avoiding them.

These strategies were very different from those employed by flight attendants. They also recognised and labelled difficult passengers, but were taught to manage any feelings of anger or irritation with passengers while continuing to interact with them.

Sessions on death and dying were usually conducted by the general tutors. The following session was led by a tutor who was completing a counselling course and was interested in how students managed their emotions. Talking about working on the oncology wards one student said:

You get to lay out so many people, you know how to do it. It's gruelling, horrible, but I'm not so afraid of death now.

T. Who helped?

S. One of the staff nurses. You become so blasé on a ward like that.

S. Nurses on the oncology wards, it's ruining their career, the involvement with patients becomes too much. They're now hard.

S. You feel cheated when a patient you've looked after dies whilst you're off duty.

S. The trained staff just don't want to know.

T. They need to develop counselling skills and build up support.

The second account of classroom activities draws attention to strategies for dealing with death and dying by which nurses become 'blasé' and 'hard'. That nurses needed to maintain empathy with patients was suggested by students who described 'over involvement' and subsequent 'hardness' as ruining staff nurses' careers. It appeared that the lack of training in techniques for managing emotions was seen to result in a withdrawal of emotional labour. As first year students, nurses still wanted involvement with patients and felt cheated if those with whom they were involved died when they were not on duty. The trained staff's 'not wanting to know' again suggested withdrawal of emotional labour by failing to acknowledge the students' feelings about the deaths.

Although emotional issues were skilfully discussed by the tutors who led the sessions, neither offered the students specific training in techniques to manage their feelings. One tutor acknowledged that trained staff on the oncology ward needed to develop counselling skills to offer support to others, but did not develop the discussion. The validity of the students' descriptions of the emotional labour process on the ward is supported by findings presented in chapters 5-8 below.

'Critical incidents', a teaching technique developed by a senior tutor at the school (Clamp, 1980) was used, in which students drew on

incidents from their work on the wards to learn about their feelings, behaviour and attitudes. The underlying assumption of the technique was that, by exploring in detail incidents from their daily work, nurses could assess the influence that their attitudes had on standards of patient care. The use of critical incidents could have shown students how to manage their feelings whilst caring for patients. However, as the following account illustrates, the tutor and students did not necessarily share the same view of the learning process. During one session attended by the researcher, students described a range of feelings experienced whilst in contact with patients. Although they were offered peer group support and empathy after the incidents, the way in which they described their feelings suggested they had invested emotional labour at the time to maintain an outward appearance of calm at great emotional cost to themselves.

A 'critical' incident session is described during module 12. Talking about the use of critical incidents as a basis for discussion in the classroom, a tutor reflected that the session:

...may have started off as a grouse session but we were trying to learn from it, and I think ... if you control the discussion firmly enough without being seen to control it, you can in fact pick the things out that you actually ought to draw attention to, the things you can learn from ... (The students) each have a variety and a richness of experience to offer ... if you can get them to the point they see they are learning from it.

A student saw the critical incident session in another way:

All we are doing is a group of friends having conversations, and because of the title of the lesson and the planned work for the week, because it says 'critical incidents', it gives people who have been a bit shy about mentioning something, will say it to their friends ... just their expression is enough to help support them because they understand.

Students described incidents in which they felt fear because an aggressive patient on nights threatened to throw his bed at them, guilt for escorting an abusive, uncooperative patient home and persuading his desperate relatives to take him back, and failure at being unable to cope personally with an offensive patient.

The limitations of the critical incident session were articulated by one of the students. During interview she described the incident in which another student talked of feeling guilty because she had persuaded relatives to accept a disturbed patient, as a means of getting him off a general ward and into a psychiatric hospital (a plan thought up by the doctors), and later discovered that the patient was still at home. The first student said:

I was amazed about that incident where the girl took that bloke home. I was almost speechless because I thought anyone who was a student nurse can understand. And what did the tutor say? 'That's unfortunate, an unfortunate situation to be in.' Unfortunate ! That girl was still screwed up about what she might have done to the emotional side of the mother of that bloke, and she has brought it up in the lecture, and she hasn't been supported.

Q. That hasn't been taken up?

Of course it hasn't been taken up. It was a conversation. They hoped that because she could say it out loud, she could be supported. They hoped that because they can say 'Well it's no problem, dear, because as long as the staff nurses knew that it was their decision to send him home, you're not guilty. Don't feel guilty '. Certainly if you are trained to be a nurse, she knew she didn't do what she should have done. And she is the one who had to convince that woman to take her son into a home that is falling apart. She was the one who promised that woman, who made all those longstanding arrangements with that woman, and I felt so much for her, because I thought 'Where were you when you found that boy was still at home? Were you standing at the phone, or sitting at report and staff nurse passed it to you as a bit of gossip, and your heart sank because you were the one who had promised his mother.'

The student continued:

I don't know if you heard me, but I did ask who went in that ambulance. Two student nurses. That is appalling! Some doctor has said that it is the only way to get somebody out of hospital and has made his decision and wiped his hands of the situation and it went down until it could go no further. And what was she told when she left the ward? 'We have a lot to thank you for'. They should be doing more than thanking her. She will probably have that memory always.

This vivid account of the feelings generated in one student by the recounting of a critical incident revealed that the full emotional impact of the incident was not explored in terms of its potential effect on the student concerned. It also demonstrated the way in which the hierarchical structure of the hospital allowed emotional labour to

be withdrawn and deflected downwards to the junior members of staff.

The psychiatric module towards the end of the second year went some way towards training students to do emotional labour. The module was identified by general tutors and students as having an important role in developing communication skills and psychological understanding.

Talking about students' personal development during interview, a tutor was asked if there was a particular stage in their training where they appeared to develop personally more than at others:

Yes, psychiatry for the majority. There is something about the whole atmosphere of a psychiatric hospital which seems to be particularly good for them. It's the fact that somebody values them as a person. Someone values their contribution, listens to what they say. It's so different from anything they have come across before. I think they get a lot of time and attention ... even the ones who say 'I don't want to do it again' on the whole would say 'yes, I hated it but it was well worth doing'.

A student who did not enjoy her psychiatric experience confirmed the tutor's observations.

It taught me a lot, I think. It teaches you a lot about the importance of talking to your patients and that sort of psychological side of their care ... I think you are much more aware of it.

Other than the psychiatric module, the limited number of sessions categorised as psychosocial nursing suggests that students received little formal training in the emotional labour techniques described by Hochschild (1983). Rather, the presence of affective/psychosocial sessions put students under added pressure to labour emotionally for patients without the necessary skills. The psychiatric module attempted to rectify this but since the module lasted only nine weeks, its long term effects were probably of limited value (Collister 1983).

However, the majority of students thought that they learnt communication skills informally, through role modelling and experience, and not in the classroom. A student who had just taken her state final examination said that she learnt by watching other people and identifying 'a good model'. She continued:

You think 'I'll remember that', or 'that's not the way I'd do it'. Then again it's almost inspirational or off the cuff. You think 'I've never met this before; I've got to act'. Or you go off duty and think how you handle something and sift through it.

Third warders said the following:

You can't be taught to react ... I think if you want to talk about things (like death), you usually talk about it to your friends when you come off duty.

Sometimes you do need support with very confused patients. You need someone (at night) to be able to turn to and say 'what do I do?'

It comes with practice anyway. The more you come in contact with, say, violent patients, you learn how to cope with that yourself because that's how the third years have learnt ... just through experience.

Many of the students considered that they were already able to communicate with others because of the sort of people they themselves were and what had motivated them to come into nursing. A first year student said:

You have to be able, even as a first warder, to have the character to be able to talk to strangers, and very quickly. If you haven't got that I don't think you can nurse well.

About the nursing process and communication skills, another first year student said:

I think that if you're basically a sort of caring person, which presumably you are if you come into nursing, then I think you've your own sort of procedure. I don't think you should try and make everyone the 'standard' nurse.

Both these comments reflected the predominant ideology of nursing as care work. Even though students described themselves as 'caring' people, they objected to the popular image of nursing as a vocation and nurses as angels. One first year student said:

Patients call you an angel. I tell them I'm doing it not to go to heaven but as a job. They can't understand that I'm doing it because I want to.

Two other students at the beginning and end of training described reasons for withdrawing emotional labour, despite expectations to be 'nice' to all the patients. A first warder admitted:

I'll never say I particularly like all the patients. You're told

you've got to be nice to them but I don't think you have to be if they're not being nice to you.

A student who had just taken state finals also described:

... times when you're tired, you do and say things you wouldn't normally do. I remember the first time I snapped at a patient I felt mortified, as I thought nurses never show that they are personally hurt. Now I don't take that view.

4.3.3 Supervision

As discussed above in section 4.1.2(b), methods of assessment, especially ward reports, set the tone for emotional labour and served as a form of indirect supervision. A student at the end of her first year of training articulated it in the following way:

In this hospital there is a very definite attempt to make you change your character ... well ... mould you into a 'City' type ... a fairly upper class ... I can't define it.

When asked to describe a sister or staff nurse whom she considered to be this type, she described a surgical ward sister who had trained at the hospital:

She's everybody's ideal, really. She's so sophisticated, she always looks so calm, attractive, and manages to get all the work done. She's very kind and considerate and yet she looks almost like a model ... I think the standards and ideals here are very high: what they want you to be. They want a lot of confidence from you very quickly. This continuous assessment thing, they're always pushing you to be more confident and I think it's quite difficult to see how they want you to behave as they don't want you to be 'cocky'.

Q. Who are they?

School and the staff nurses, I suppose. I don't know who formulates the ward reports ... a list of all the qualities you should have. You get marks on them. It's whoever draws up that who is moulding you.

Another student at the end of training described nursing as:

... quite a tough job. I mean every eight weeks you are sort of having these ward reports ... which is really okay looking at the good and bad points in your work, but it's also a lot of character bashing - I think, anyway.

During interview with two students in their third module, one of them concluded that the reports :

... give you a picture of what they think you were like; not like I think I am ... it depends how confident you are. That's all they're interested in - 'confidence'.

A student in her third year described the emotional cost of caring and the effects of being continually assessed:

The general public says 'why do nurses put up with all the pain, long hours, low pay?'. When you are talking about having my identity crushed and concepts of something which was so important in my life just tipped upside down, what does low pay matter?

4.3.4 The school as a social support system for students

Since students received a limited amount of formal training to do emotional labour, but were continuously indirectly supervised in its delivery, the researcher wanted to find out the sources of support available to them from the school of nursing.

The plan of training was divided into three units, representing each of the three years. A team of tutors were responsible for students in each unit. At the end of each year, students and tutors changed and passed on to other groups. During that year each student was assigned an 'academic' tutor from within the team. Advice could be sought on written assignments and the tutor was responsible for the students' professional appraisal at the end of each module. In addition, a personal tutor was appointed for the three year training to whom the student could go with personal and work related problems. The rationale was that students were able to keep separate personal and academic matters.

It was emphasised that students should feel free to consult with whomever they wished, despite being allocated particular tutors. In practice students changed academic tutors annually and also noted the separation between the personal and the 'professional' aspects of their work, since they were assigned two different tutors. Although they had a 'personal' tutor for the duration of the course, they appeared to find difficulty in building up an ongoing relationship with someone whom they could identify with and seek support from. One student at the end of training expressed a common view when she said:

If you wanted support they (tutors) would give it, but because you haven't built up a relationship with them they're like strangers.

The students were conscious of the ambiguity in their tutors' roles and many of them did not use the tutors to seek emotional support as they felt they might be judged negatively:

You've got to respect a position of authority but you shouldn't be scared, (like you think) 'Oh god, she's going to be writing something about me'. I don't want to be feeling like that (about the school) for three years.

You can't go and say anything to them (the tutors), because you know that they'll go and discuss you.

Sometimes you hear about stuff going on in another set, and that's awful.

The students did, however, express the need for a person and/or institution which represented their interests and was 'responsible' for them. One group of students in their third module approached the researcher after filling in the Fretwell questionnaires, and said they felt as if there was nobody, either on the wards or in the school, who was accountable for them personally. They felt as if they were 'on their own'. One student at the end of training was 'surprised at the lack of support' given to nurses by the school.

Students referred to tutors whom they had found supportive in the past. When asked what distinguished these tutors from others, the students described them as:

Approachable, not so middle class, always funny when they gave tutorials, and did not put on 'airs and graces'.

Tutors, however, expressed a commitment to supporting students. For example, a senior tutor said:

I happen to believe that one should have an open door, so I don't have office hours. And if I'm in my office and a student has a problem then I see them there and then. I can always pick up the bits of paper but can't always pick up the pieces of a student.

Another tutor described the reasons why students came to see her:

They come at a crisis point, a mini-crisis, when there is just too much pressure on them at that time and they just need someone to talk to. It's usually problems on the ward, problems with boyfriends, 'State' coming.

In summary, nurses were selected and supervised to do emotional labour at City hospital, but were inadequately trained in techniques essential to managing feelings. The hierarchical system of health care appeared to facilitate the withdrawal of emotional labour and to deflect the onus to carry it out to the junior members of staff. The hierarchical relations within nursing in general and the school of nursing in particular militated against more open and supportive relationships between students and their teachers. Students rarely observed emotional labour being undertaken on their behalf and were given only limited guidance on how to manage complex feelings.

The ideology of nursing as care work was not adequately reflected, nor catered for, in either the content or methods of training. In subsequent chapters, these findings are explored further in pursuit of the conceptualisation and interrelationship of quality of nursing and the learning environment on the wards of City hospital.

CHAPTER 5

THE NATURE OF THE NURSING WORK AND THE LEARNING MATERIAL

Introduction

Chapter 5 is the first of four chapters (5-8) which describe the dual activities of nursing patients and learning nursing in the context of different ward environments at City hospital. The nature of the nursing work and the learning material is described through the data in order to examine the early working hypothesis presented in chapter 3, that students judge the ward learning environment according to the characteristics of the patient population which include age, gender, race, dependency, technical and basic care required; and that their perceptions of learning on each ward are also influenced by their stage of training and unique learning trajectory.

It was established in chapter 4 that the content and form of nurse training at the City school of nursing was dominated by a medical and disease rather than a nursing orientated approach to patient care. Hence, students' expectations for learning on each ward were shaped by a modular plan of training based on medical specialties rather than the nursing process and its underlying theoretical framework of communication skills and activities of daily living.

In this chapter, hypotheses are developed in order to examine whether students were more likely to associate good learning environments with wards that had patients with a variety of diagnoses requiring technical care and specialist medical intervention, rather than those with a high percentage of dependent elderly patients requiring 'basic' nursing care. The identification of the nursing process, the 'affective' elements of nursing as work, its status as learning material, and the need to do emotional labour on different wards, is examined. The influence of stage of training and pattern of

ward allocation on shaping students' perceptions are also assessed.

The findings are derived from (a) interviews with students and tutors; (b) field observations from four study wards; (c) document analysis; and (d) self administered questionnaires on students' attitudes towards the ward learning environment.

The chapter contains five parts. The first part describes patterns of ward allocation for students at the City hospital. The second part presents findings from interviews with tutors and students on the nature of the work and the learning material. These data are used to examine the notion of the learning trajectory and stage of training on shaping the students' perceptions of the ward learning environment.

In the third part, the interaction between the nature of the work, learning on the ward and stage of training are demonstrated with four ward case studies. The case studies bring together data collected through field observations, interviews, questionnaires and document analysis.

The fourth part examines questionnaire findings on the ward learning environment in relation to the nature of the work and the learning material. As stated in chapter 3, the item, section and overall scores for different aspects of the ward learning environment, together with an analysis of comments to open-ended questions 37-39, are used to confirm hypotheses generated from other data sources. A final part summarises and discusses the findings obtained through the different methods of data collection.

5.1 Patterns of Ward Allocation for Student Nurses in Training at City Hospital

As described in chapter 4, it was found that the plan of training at the City school of nursing was divided into 15 modules based on medical specialties and disease orientated clinical learning objectives. Students spent approximately four-fifths of their time in each module on the ward as opposed to one-fifth in the classroom. During the first

and third years of training, there were two modules each of medicine and surgery (eight modules in all), suggesting that priority was given to students gaining experience in general/specialist medical and surgical nursing. On the basis of these findings it was decided to analyse the nursing work and learning material actually available on the medical and surgical wards of City hospital to find out to what extent they corresponded with the students' learning needs as stated in the plan of training.

An analysis of the bed allocation on the medical and surgical wards of City hospital was undertaken. It was found that the majority of beds were designated general medicine (106) or surgery (114) out of a total of 608 beds. However, on closer examination it was found that consultants with both general and specialist interests were allocated a number of beds, usually on more than one ward.

The school of nursing appeared to have no control over the designation of beds in the wards of City hospital and the characteristics of the patient population were determined by medical consultant rather than nursing interest. For example, on 8 medical wards there was a minimum of 3 consultants on each, with a range of specialist interests subsumed under the general label of 'general medicine'. These specialist interests included endocrinology, gastroenterology, haematology, metabolic disorders, and respiratory medicine.

Students were likely to meet a range of patients on a number of wards who were suffering from a variety of conditions irrespective of the designated specialty of the ward, as the following examples demonstrate.

Loughrigg ward was predominantly a neurology ward, but also had 9 neurosurgical beds. It was designated as a medical ward for the purposes of student allocation. The opposite situation occurred on

Helvellyn ward, which was designated as a surgical ward for the purposes of student allocation. Out of a total of 18 beds, only 8 were allocated to patients undergoing surgical ophthalmology. The remainder were for patients suffering from predominantly medical conditions, such as rheumatological and metabolic disorders.

Before February 1985, all the 8 'general' medical wards had a number of beds allocated for patients of 65 years and over who had been specifically admitted under the care of the consultant in geriatric medicine rather than consultants in general medicine or other specialties. After February 1985, all the geriatric beds distributed throughout the 8 wards were concentrated on 2 wards. The 'vacancies' created by the transfer of the geriatric patients from the 6 wards were redesignated as general medical beds and Tarn Hows, which until that time had had 10 geriatric patients for rehabilitation and discharge, became a neurology ward.

Students in their second year had been allocated to Tarn Hows as part of their specialist geriatric ward experience. Langdale ward took over this function after the transfer of geriatric patients in February 1985. Edale ward continued to be designated as a general medical ward allocation, as did Tarn Hows ward following the change in specialty from geriatric to neurological medicine.

According to nurse managers, the rationale behind retaining Edale ward as a medical ward allocation for the purposes of student nurse training was based on the characteristics of its patients who were admitted for assessment and acute medical treatment and therefore were similar to general medical patients. However, all the patients were over 65 years of age and under the care of the geriatricians as on Langdale ward, now a designated second year geriatric ward allocation.

These examples serve to illustrate that patients did not necessarily conform to the characteristics expected of them by students from their

plan of training and that patient diagnoses did not always correspond to the designated medical specialties of the ward as Roper had found (1975).

One of the reasons for these incongruities, according to the City nurse allocation officer, was that students were used as 'pairs of hands' to meet service needs to staff the medical and surgical wards. The allocation officer also said that, during their second year of training, the students were more likely to be supernumerary on specialist placements such as obstetrics, psychiatry and paediatrics.

The allocation officer agreed to the suggestion put to her by the researcher, that the general placements in particular needed to be planned systematically in order to ensure that students met their learning needs. She hoped that in the future she would be able to introduce computer programmes for planning comprehensive and systematic ward allocation for each student at the beginning of training.

During the study period, however, students knew which wards they were allocated to only eight weeks in advance. They did not have their allocation planned at the beginning of training to provide them with the optimum training environment based on duration and number of placements, workload, staffing levels and patient specialty as suggested by Moores and Thompson (1975) and Moores (1979).

On the medical and surgical wards in particular, where students were used as 'pairs of hands', the allocation officer explained that it was much easier to make each ward allocation for each student during training so that she could respond to staff shortages on particular wards at any given time. Staff shortages might arise from students or trained staff leaving which would deplete the ward establishment of ward sister, 5 or 6 staff nurses and 10 third and first year students. The students therefore constituted nearly two-thirds of the work force. If they were already allocated to wards at the beginning of training

and they then left before completion, the allocation officer explained that she would be unable to make up the ward establishment by allocating extra students since they would already be allocated to other wards.

The allocation officer had established some rules to ensure that students' minimum learning needs were met. For example, if students' first ward placement was a specialist medical ward, she would then send them to a 'general' surgical ward. She also avoided allocating them to medical wards on the same floor throughout their three year training, in order to prevent repetition of medical specialties.

Halfway through the study period (October 1984), the allocation officer responded to recommendations of an education officer not to allocate first ward students to oncology and neurology wards. The rationale behind the recommendations was that these wards were too stressful and/or specialised for first warders to be able to take full advantage of the learning potential available.

Reduced intakes of students to City hospital as part of management cost-cutting strategies also facilitated the decision not to send first module students to those wards as there were fewer first year students available than third years.

From the allocation officer's account, patterns of ward allocation suggested that students were placed primarily to fulfil staffing rather than learning needs. The students agreed with this suggestion, as is characterised by the following example:

You go on the ward. You're not the student nurse at all ... You're the work force, and if you do learn anything, then good for you!
(Third ward student)

The issue of student as learner and worker is explored further in section 5.2 below.

In summary, the above account of patterns of ward allocation confirms the findings that nurse training was organised around medical

specialties which did not necessarily offer an accurate view of the learning material available to student nurses on the wards at City hospital. Students' learning needs appeared to be secondary to the service need to staff the wards. Although an education officer could impose bureaucratic authority to meet perceived learning needs of junior students by changing first ward allocations, the main determinants of the learning material on any one ward were the consultants.

5.2 Interview findings

During interviews with students and nurse teachers, views on the nature of the nursing work and learning material on different wards and at different stages of training were sought. The people and incidents from whom and from which students had learnt were identified. Findings related to learning situations and illustrative of the nature of the nursing work and the learning material are presented here. Findings related to the people from whom students said they had learnt are presented in chapter 8.

Students' and tutors' accounts are grouped around issues which address working hypotheses. These issues and hypotheses are related to: student as worker; learning trajectories and patterns of ward allocation; the nature of the work and the learning material: patients to be nursed according to diagnosis/medical specialty, dependency, technical, basic and affective nursing required; age and gender; students' stage of training; and night duty.

5.2.1 The student as worker

As stated in section 5.1 above, students were the main workforce and their learning needs were secondary to the need to staff the wards of the City hospital. That students recognised the duality of their role as worker and learner is illustrated by the following statements:

The people who as a group of people care most for patients are the student nurses, because there are more of them. (Third year student)

This statement is supported by a study that showed that in some hospitals up to 75% of direct patient care was given by nurses in training (Moore and Moulton 1979).

Another third year student found difficulty in separating a 'good ward to learn in from a good ward to work in'. The student's statement implied that the two activities of learning and working were, for him, virtually indistinguishable. As quoted in section 5.1 above, a third warder was in no doubt as to the pressure on students to perform primarily as 'the workforce' rather than as learners. A senior member of the tutorial staff confirmed the students' position as the workforce rather than learners when she said:

When student nurses talk about being students, I'm not sure they actually mean they want to be students in the supernumerary sense. They mean that they don't want to be pairs of hands and want recognition of their learning role. That's the problem and here in City we depend on them as a workforce.

Additional evidence of the students' worker role came from the report mentioned in chapter 1. This report was just one of a series which over a number of years had criticised City hospital's nurse management for relying too heavily on the students as the workforce. There was even a suggestion in the report written in 1981 that the reliance on students as the workforce had arisen because:

The presence of articulate student nurses with an understanding of clinical medicine, rather than untrained supporting staff, is also thought to be more acceptable to the medical staff of a teaching hospital.

The implications of this statement support the view put forward by the Assistant Director of Nurse Education (ADNE), who said she selected students to work at City hospital if she thought they could 'stand up in a professional environment' (section 4.3.1).

These findings suggest that the use of students as the workforce at City hospital was consistent with the literature which, throughout the history of nursing until the present, described and criticised the use of students as workers rather than as learners (chapter 2, section

2.2.1).

5.2.2 Learning trajectories and patterns of ward allocation

As stated in section 5.1, students were regarded both by themselves and others as the workforce. Their learning needs in the wards were secondary to the provision of their labour. Consequently, the planning of their ward allocation during training was not systematised to provide them with an optimum learning environment.

During the first and third years of training, the order of the allocation was not decided on students' individual needs but on the basis of whether a ward had a medical/surgical label. The majority of placements were of uniform duration at eight weeks each.

Students regarded a systematic ward allocation during training as good fortune rather than as a result of planning. For example, a student, after only three ward allocations, said that she felt that 'there was no awareness (by either ward or tutorial staff) about where we actually were in our training and what we'd actually done'. A third year gave the following account of her ward allocation over three years:

I found my first year to be quite varied. I preferred general surgical, medical and oncology and ENT. Second year was all the specialties. But in my third year I did three wards that were concerned with hormones, pancreas and enzymes and this sort of thing. Silverdale was mainly pancreatetectomies. Ronda was also to do with pancreatitis and I also did Langdale, which was insulin and this sort of thing. And I haven't done hearts and I've only gone to orthopaedics because I specifically asked.

A student at the beginning of the third year did not feel that her ward allocation to date had been planned:

I haven't yet worked on an oncology ward ... Rumour has it that everyone will work on one and I've only one more medical allocation to go, so I'm going to stick my neck out if I'm not sent there. I did eight weeks on female heavy, medical, general ... it was very hard work, very good general nursing ... and then I was sent for a short allocation to another heavy general medical ward. The hospital has this reputation of having these three female heavy medical wards and I've been to two of them (Langdale and Windermere). I did quite enjoy it but I didn't actually gain knowledge that second time.

Both accounts illustrate the following points. Firstly that students judged their learning trajectories according to the medical specialty of the ward; secondly that they liked variety and resented the 'repetition' of a specialty; and thirdly that they might request ward allocations which they perceived as necessary to fill gaps in their learning. Of interest in the second account is that the student suggested that 'heavy, female, general, medical wards' did not provide sufficient knowledge to merit two ward allocations.

Another student drew attention to the impact of bed reorganisation within the City hospital in terms of the nature of the work and the learning material:

I suppose in lots of ways ... the hospital, because of the way it's been changing over the past two years ... I suppose it is a very different hospital from when I started, especially now with two surgical wards closing. I think if they hadn't I would have been going there next, as I haven't done a general surgical ward.

The student was articulating the impact of bed reorganisation on student nurse training, in terms of medical specialities, the loss of which would detract from his own learning trajectory. All three accounts were typical of the students' views of the nature of the nursing work and the generation of learning material based on medical specialties. These findings are consistent with Fretwell's (1982), who reported that students perceived 'basic' nursing as work rather than learning, which they associated primarily with 'technical' activities.

That the medical specialty of a ward might have implications for the nursing work, rather than being synonymous with it, was inherent in the statement made by a finalist:

Here (City hospital) wards are so keyed up to a certain specialty, and that is what they are good at and that's what they deal with - not nursing care wise but the doctors, who are orientated in that way. And when you get a patient who isn't of their sort of norm, then they do tend to be at a bit of a loss.

However, few students made the distinction between medical and nursing work in this way.

The uniqueness of the learning trajectory of each student nurse as s/he progressed through training was described by a senior tutor in the following way:

If you have got 28 students, they may well have been to something like ten different wards; they have different experiences. Even people in the same ward will have different experiences. You may well have a student who on her night duty on the ward had a death every night. And you will find another student in the same group who also worked on the ward and has not seen a dead patient in three years of training. There are students who have been present at at least three or four cardiac arrests. And others who have taken their finals, got their results and never seen one.

The tutor's observation was confirmed during interview with students. For example, a student who had just taken state final examinations said:

I have gone through my training and I just haven't seen an arrest, and coming now in my third year I would be expected to cope.

Another student at the same stage of training had recently laid a patient out for the first time:

When you're a third year you're expected to have seen most things and done most things.

She then went on to give an example:

Somebody died and sister said to me 'Well I think you can take care of this now.' Neither me nor another third year had done it (last offices) before. But we wanted to because we thought 'It's about time.' It just happens. You sometimes miss things like that.

On her last medical ward allocation a third year described an incident when the ward sister had put down a naso-gastric tube on a patient without asking students if they would like to observe the procedure.

The student commented:

We could easily have watched her do it. OK, it's the trained staff's own thing but as third years suddenly you are qualified and you are expected to be able to do things like that.

As the above accounts demonstrate, third year students frequently expressed anxiety that they would be expected to have witnessed various 'key' technical procedures by the time they reached the end of their training. The procedures most frequently mentioned were managing a cardiac arrest, last offices and passing a naso-gastric tube.

Thus, the content of the learning trajectory appeared to depend on which wards students were allocated to at certain stages of their training, which shifts they were on duty and the particular patients on the ward at the time of their placement. Stage of training, therefore, shaped expectations for what students should be able to do rather than the actual experiences they had accumulated as they progressed through training.

The above accounts highlight the following issues related to the nature of the nursing work and the learning material, which are developed below. Firstly, that students valued wards with patients who offered a variety of technical and medical experiences, rather than 'heavy, female, general, medical wards'. And secondly, that the stage of training rather than the content of previous ward experiences was important in determining what a student was expected to be able to do. Students monitored their own learning trajectories and to some extent were able to influence the planning of their subsequent ward placements, by requesting specific allocations to fill perceived gaps in their learning.

5.2.3 The nature of the nursing work and the learning material

The findings presented here, on students' views of the nature of the work and the learning material on different wards and at different stages of training, develop further the findings presented in section 5.2.2. Firstly, the finding that students valued wards where patients offered a variety of technical and medical experiences is considered. The identification of the nursing process and the 'affective' elements of nursing as work and its status as learning material are also examined. Secondly, the age and gender characteristics of the patient population are explored. Thirdly, the finding that the stage of training was important in determining what a student was expected to do on a ward is explored further in order to examine other ways in which stage

of training shaped perceptions of the learning material on different wards.

- (a) Patients to be nursed: according to their diagnosis/medical specialty, dependency, technical, affective and basic nursing required and the use of the nursing process

When asked during interview whether the specialty of the ward was important to her learning, a third year student responded in the following way:

Yes, well, I think so without a doubt because you learn from what is wrong with them (the patients) ... I think it is very blind of anyone to say 'Well it is all nursing, it doesn't matter where you are, you will learn.' It is true you will learn, but surely it matters in three years what you learn.

The student's response summarised the view held by many students on the importance of the medical specialty of the ward with regard to learning, and their lack of recognition of nursing as a distinct activity. Her response also complements other students' views on the theoretical content of nurse training as described in chapter 4, that nursing was not seen as offering a viable alternative to medicine as a knowledge base.

By the time a first year student had reached her third ward allocation she was already beginning to form the following viewpoint:

It (Loughrigg ward) was really interesting. I mean it wasn't like Windermere or any other medical ward, because there were loads of different illnesses and multiple sclerosis and all that ... and people coming in for tests and lumbar punctures and things.

The first year student appeared to be rating medical specialty and technical nursing on Loughrigg ward as more valuable to learning than the type of nursing work and learning offered by Windermere and 'other medical wards'.

During the first year, students were allocated to surgical wards following first and third ward medical placements. A student, on completion of medical module one, looked forward to 'learning things again' at the beginning of her first surgical module, suggesting that she felt she had learnt all there was to learn about nursing medical

patients, after eight weeks on a medical ward.

Other students expressed similar views about the superior nature of the learning material on surgical wards. At the end of their third ward allocation students on a medical ward talked about the differences between medical and surgical wards in the following way:

Student C: I've worked for nursing homes and really ... I don't think I've learnt a lot more on the medical wards than I did when I was working in the nursing home, and on the surgical ward you just learn so much more, really.

Student L: On surgical wards, there are perhaps more techniques going on, which you can learn from watching them being done.

A discussion group with four of L and C's colleagues proposed the view that surgery was 'a completely different type of nursing' from medicine, because 'you have to be more alert'.

The students' views on differences between medical and surgical nursing corresponded in part to findings of a study by Lentz and Michaels (1959) reviewed in chapter 2. The study reported that surgical ward nurses were more technically skilled than their medical counterparts. Students in the present study appeared to recognise the technical skills required for surgical nursing. They did not appear to recognise, however, the expertise of nurses on medical wards which, according to Lentz and Michaels, lay in the quality of their relationships with patients.

In a second study reviewed in chapter 2, Parkes (1980) reported that students were more likely to be critical of a medical allocation following a surgical ward placement. It is interesting to speculate whether the views expressed by the third warders tended to be more critical following their first exposure to surgical nursing in their second module. Parkes also found that students consistently rated surgical nursing more favourably than medical nursing during their first year of training because of its association with acute, technically orientated care. Similarly, in the present study, a student

at the end of training looked back favourably to what she saw as a 'good' learning experience on the gynaecology ward:

I learnt a lot there about surgery and how to care for surgical patients, because there was a very quick turnover. And we had a lot of emergencies ... and that was very useful.

It began to emerge, during interviews, that the criteria which students used to judge the value of the learning material available on a ward, based on medical specialties and technical procedures, were also applied to the use of the nursing process (and hence its learning potential) on a ward. Thus students assessed the use of the nursing process according to the nature of the medical, technical and physical work generated by the patient population and the adequacy of the staffing levels to carry out that work. The heavier the physical work in terms of the nursing care required by patients, the more impractical it became in the students' eyes to use the nursing process. The nursing process was seen as less appropriate to nursing acute medical and surgical patients than patients requiring assistance with their daily living activities. The following quotations illustrate some of these views. Third year student:

On the last ward I was on (surgical), we were very busy for a few weeks and the nursing care plans didn't get done. But things carried on the same as usual which makes you doubt it (the use of the nursing process) a bit.

First year student talking about the nursing process philosophy of individualised care:

I think that this ward (Loughrigg) was able to be geared towards the individual, because there was a lot more time to do things because it wasn't really busy.

A third year student talking about the conditions favourable to the implementation of the nursing process said:

On most wards I have been on, it hasn't worked as it was designed to, because of how the staff want to work, how busy it is and what kind of work ... The ward where it really works is Tarn Hows (geriatric rehabilitation ward), which is ideal. The place is running well as there are more staff than on most wards and less patients. You just have to help old people get up in the morning and

get dressed and persevere with them.

It may be inferred from these comments that students appeared to describe the nursing process as being more suited to wards where patients required assistance with activities of daily living rather than acute technical care. It is suggested by implication that the nursing process was associated with learning material of lower status in the students' eyes than learning material generated by patients requiring acute technical care. These findings support the discussion in chapter 4 (section 4.2.2) that the theoretical content of nurse training still emphasised a medically orientated rather than a nursing process approach to care. The nursing process is discussed more fully as a working and learning strategy in chapters 6, 7 and 8.

Only two students explicitly valued the learning material generated by patients on City's 'heavy, female, general, medical wards'. During separate interviews they spoke positively of their allocations to Windermere and Coniston wards respectively.

A finalist who had recently worked on Windermere thought that it was 'brilliant for first years' because of the good basic experience it offered. She similarly assessed Langdale and Coniston wards. She described herself as 'going overboard' for Windermere ward. The student went on to explain that these wards were not generally popular allocations for learners because of the high patient population of 'little old ladies.' She was aware that the rest of her set thought she was 'mad' because of her enthusiasm for Windermere ward.

Another student at the end of training said about Coniston:

The reputation of my last ward was that it was mostly basic nursing care.

Q. What affect did it have on your learning?

A. It made me realise what an art it is. Maybe it's a sign of more experience.

This student later went on to be a staff nurse on Coniston ward. It is

also interesting to note the point being made about experience. It may be inferred that the student was only able to value the learning generated by nursing dependent elderly patients with the insights that came from more experience (the student was also a 'mature' entrant to nursing) and from a personal preference for nursing rather than medical specialties and technical procedures.

That students acquired insights about the nature of nursing work and the learning material as they gained more experience was illustrated by another third year. In relation to what she described as her understanding of patients' psychological needs, she said:

You don't realise what people's needs are when they are in hospital, not even during your first year. Then it starts to dawn on you. It was on Wastwater (oncology), my third ward, where it dawned on me the amount of psychological needs that people have.

It is important to note that the student identified the patients' psychological needs on an oncology ward. Other students made links between the medical specialism of oncology and the technical as well as the affective nature of the nursing work. A third ward student said about her allocation to Wastwater:

It (oncology) kept you interested rather than having lots of patients with different things ... you had really intensified stuff.

About another oncology ward (Buttermere) a student also on her third ward said:

I learnt about human emotion I suppose, really. And you see the patients in such a lot of trouble ... There are such a lot of advances in oncology anyway and oncological techniques ... and you should give it the credit it deserves. There is a lot of work going on and it is specialist nursing, there is no doubt about it. It's not like anything else and it should be given the time it deserves. And if you can go through your training not having worked there then you have missed out on a lot.

Thus students, especially as they became more senior, appeared to identify affective work and the need to do emotional labour as part of nursing when these activities were legitimised through the medical specialty of oncology. The following comments made by a finalist on her last allocation to Helvellyn, an ophthalmology ward, further illustrate

this point:

I would have liked to have been taught about 'the eyes', really ... I mean it's quite fun chatting to the patients but the actual nursing is boring. Anybody can bathe an eye. But I dare say if you are an opthamologist ... in a clinic ... then it's great fun ... that's another thing. It's more a doctor's thing than a nurse's from my point of view.

Like the student commenting on ward specialisms in the City hospital (section 5.2.2), this student saw nursing activity as distinct from medical specialties. However, she also made links between the medical specialty of oncology and the affective care of nursing:

I don't know. Maybe oncology is much more a nurses' world because there is so much psychological care there.

In other words, this student perceived oncology patients as generating affective nursing and emotional labour, whereas patients on an opthalmology ward did not.

It may be inferred from the above accounts that students associated wards with a variety of diagnoses requiring technical care and specialist medical intervention as better ward learning environments than those with a high percentage of dependent, usually female, elderly patients requiring basic care. Affective nursing and emotional labour were most clearly identified as part of the work and learning agenda on oncology wards. This finding was supported by Strauss and colleagues' (1982b) exposition of sentimental work in the technologised hospital.

The use of the nursing process was more likely to be associated with wards that were well staffed, with a low workload and where dependent elderly patients required assistance with activities of daily living, rather than acute technical care.

Since age and gender also appeared to constitute important patient characteristics in terms of the nursing work and learning material on wards, the next section of the chapter will look more closely at each.

(b) Patients to be nursed: age and gender characteristics

As was established above, three wards in City hospital were

considered to be less popular ward allocations because of the nature of the work generated by their patient populations. These wards were Coniston, Windermere and Langdale, where patients required help with activities of daily living (defined by Goddard (1953) as basic nursing) rather than technically orientated medical interventions such as occurred in cardiology, oncology and neurology wards. Patients in the main on those wards were younger and hence by definition could do more for themselves. These findings are consistent with Kelly and May's (1982) literature review, in which they concluded that certain characteristics such as age and gender affected doctors' and nurses' perceptions of patients. The most popular patients were young with prospects of full recovery, in response to specific medical and technical interventions by doctors and nurses. One first year student articulated age as a patient characteristic in terms of the nature of the nursing work in the following way:

You can have all these ideas about what you would like to do but when you've 20 geriatrics it's not just the same at all. And I know it should be because they are all people, but it's not. It's not the same as looking after a 30 year old person or a 40 year old - you've got a lot more consideration for their feelings. I suppose you shouldn't have. But I mean it's a lot more work involved on somewhere like Windermere (than Loughrigg) and you have got to get everything planned and do everything in a certain way.

As already stated and to be shown in the ward case studies below, Windermere had only 2 officially designated geriatric beds. Other wards such as Coniston and Ronda had many more, at 6 and 9 respectively. However, Ronda did not acquire the label of being a 'geriatric' ward. Part of the reason for this may have been because the designated geriatric beds were for male patients. Toileting, for example, was seen to be much less time consuming, as urinals rather than commodes and bedpans could be used for the majority of dependent patients' toileting purposes.

From the students' reaction to the patients on Windermere ward it

appeared that 'elderly' female patients were equated with being 'geriatrics'. Also the work that they required was physical and did not leave time for caring for patients' affective needs. This view of the nature of the work in terms of its physical and affective components is explored further in the ward case studies in section 5.3 below.

However, as stated in section 5.1 on patterns of ward allocation, students reacted negatively to the designation of Edale ward as a medical ward allocation after the transfer of all the designated beds to male geriatric patients. Gender in itself therefore was not sufficient to lessen the students' overall negative reaction to elderly patients. However, since demographically there are more elderly women than men, it is hardly surprising that the three female, general medical wards in City hospital were associated with elderly, physically dependent and therefore 'heavy' patients.

In the second year of training, students undertook an eight week geriatric allocation. They gained their experience in the long stay geriatric hospital some miles away from City or in Tarn Hows ward, which was described by one student as an 'odd' ward. This comment seemed to originate because it did not conform to the stereotypical geriatric ward, i.e. short staffed, patients who were longstay; or general wards because there were no emergencies and there was a high patient-staff ratio (3:1). In other words conditions were 'ideal' for giving planned, imaginative nursing care. The student now in her third year said:

Tarn Hows was a very very odd ward because it only had ten beds; the patients were all geriatrics waiting to go home. So there were hardly any stresses, none were for resuscitation and there were no emergencies. There were the same number of staff as in other wards so we only had three patients each on average.

The above accounts suggest that the status of the elderly as learning material was not based on age alone, but also depended on whether they needed technical care and specialist medical intervention associated

with medical specialties such as gastroenterology or cardiology. The nature of the work associated with elderly people, especially women, and specialties such as geriatric and/or general medicine, was viewed less favourably, and expected to be physically demanding.

In terms of gender, the association between age and gender has already been established. The work of Evers (1981b), reviewed in chapter 2, discusses the effects of gender on nurse-patient relationships in longstay geriatric hospitals. She suggests that the 'mothering' model adopted by many nurses in caring for their patients is more suited to male patients, since men are used to being serviced in their domestic lives, whereas women are used to doing the servicing.

Parkes (1980), in a study of female student nurses, found that patients' gender influenced students' job satisfaction, which they reported as being higher when nursing male patients compared with female patients.

Students' views on patients' gender, expressed during interview in the present study, reflected gender stereotypes in terms of their social relations and the nature of nursing as women's work. They also supported the findings reported by Parkes (1980) and Evers (1981b). Even at the beginning of training on the eve of their first ward allocation two students thought that they would prefer working with men because:

Women are fussy. They expect a 'hotel service' as if they were on holiday. Men are more considerate of nurses. They've got more pride to get on their feet and they don't like women doing things.

Another student at a similar stage of training contradicted the above comment by thinking that it would be easier:

... on a mens' ward, because they are more encouraging than women and they like being fussed over. Women don't. They feel their independence has gone as mothers and they say 'You should be able to do it (work) better'.

After the allocation this student still imagined that men would be easier to nurse:

Men would be more grateful. A lot of the women like to be independent. They don't like you telling them what to do. They say 'I could teach you nurses a few things'. Some of them expect you to do everything and they don't say 'please' or 'thank you'.

A student at the end of her third ward thought that women 'called out for you. Men are more sort of passive and far more independent'. A student in her third year who had been allocated to more female than male wards during her training, including two 'mixed' wards, preferred nursing men for the following reasons:

I just find men easier to talk to a lot of the time and they have got a different idea of hospitals. Women can almost expect to be waited on as if they've come in for a rest. Men want to get out of hospital as quickly as possible and they just want to be as independent as possible.

Other students found women easier to talk to because they were women. One nurse found that women were 'more open to discussion' whereas 'men see you just as a nurse'. Another student in her third year preferred nursing women and thought that 'old men touch you up'. The only male interviewee had the following views on nursing male and female patients:

Patients react differently to male nurses. Women appreciate having a man about the place. It's just a change in atmosphere, perhaps. You look upon the technicalities in much the same way, like dressings, getting your drips through on time ... In the more social aspects I think probably women talk more easily to women. I think perhaps men talk more easily to women as well, although I think it varies a lot.

From the students' accounts, it may be inferred that age and gender are recognised as affecting the nature of the work and the learning material available on wards. Gender was recognised as important in terms of the social relations between patients and nurses and their ability to talk to each other. However, individual differences were demonstrated in students' preferences for nursing men and women.

Race as a characteristic of patients as learning material did not emerge as an issue during the research, perhaps because of the relative homogeneity of the population under study. Patients admitted to and nurses selected to work and train at City hospital (see chapter 3,

section 3.3.2, and chapter 4, section 4.3.1, respectively) were predominantly white. Neither did the nurse training programme address issues of race and ethnicity. The impression gained during participant observation was that only a limited number of patients admitted to City hospital were from ethnic minorities and even fewer were non-white. The implications of race and culture for quality of nursing are discussed in individual ward case studies presented in chapter 7.

(c) Stage of training

The students' accounts of their learning trajectories and patterns of ward allocation, presented in section 5.2.2, demonstrate the importance of both trajectory and allocation pattern in shaping their views on the nature of the work and the learning material on each successive ward. Stage of training was an integral part of both trajectory and allocation pattern and did not stand alone in shaping students' views.

The following findings contribute to an understanding of the role of stage of training in shaping students' views on the nature of nursing work and the learning material during each ward allocation.

At the beginning of training, for example, students felt that they were learning all the time because every experience on their first ward was new. In the initial stages of training, therefore, ward specialty might be considered less important to the nature of the work and the learning material. For example, a discussion with students on Ronda ward yielded the following observation:

First warder: Everything I've learnt, I've learnt here on the ward. I learnt so much in the first week.

Third warder: You learn most on your first ward. You are keen and it sinks in.

A third year also commented during interview that she felt that she never learnt quite so much again in such a concentrated fashion as on her first ward.

These views on the content of ward learning were reminiscent of students' comments on their learning in the school of nursing. As stated in chapter 4 (section 4.2.1), one student expressed a representative view when she said that it was only early in training that she felt she was 'learning new things' from the weeks spent in school.

There was evidence to suggest that some wards might be identified as being more appropriate at certain stages of training than others. For example, as referred to in section 5.1, oncology and neurology wards were withdrawn as a first ward allocation during the data collection, but later the oncology wards were reinstated.

The reasons given for withdrawing the oncology wards was on the recommendation of an education officer's report published in 1984, which stated that trained staff and students had experienced the wards as stressful for junior learners despite efforts made to support them. Indeed, stress ratings on the Fretwell questionnaire for two of the wards were high (table 5.27). However, all three wards received favourable scores from module one students on the ward learning environment questionnaires (table 5.23). Indeed, during discussion with students at the end of the Foundation Unit, those allocated to the oncology wards expected their experience there to be emotionally draining but offset by supportive trained staff. The role of supportive staff in reducing students' stress is discussed in chapter 6.

The reasons underlying the withdrawal of the neurology ward as a first ward allocation are encapsulated in the following statement. A third year student looking back to her time as a first warder on Loughrigg said:

Neuro is incredibly specialised when it comes to your first ward. I was still learning how to take temperatures and people alongside me were doing neuro observations ... even when they did teach you there was only a certain amount you could take in.

How much this student's reaction was a product of the nature of the specialty and how much the experience of being a first warder irrespective of specialty, is open to speculation.

As noted above in section 5.2.3(a), Coniston, Langdale and Windermere wards were described as offering particularly suitable learning material for first warders. An explanation for this appeared to lie in the students' perceptions of the nature of the work as general and basic which they assumed to be particularly suitable to the learning needs of junior students. The extent to which this assumption was founded in reality is discussed further in the Windermere ward case study below.

In terms of third year allocations the suitability of the allocation depended to some extent on where the students had worked previously. In general, however, the technical wards (neurology, cardiology and oncology) were regarded as offering 'good' learning material. If students had not been allocated to 'general' wards earlier in their training, they also felt the need to gain such experience in their final year.

(d) Night duty

During interviews, night duty as learning material emerged as an issue for further consideration. Students at City hospital completed more hours on night duty than was actually required by the GNC (ENB, from 1983) for training purposes. Students did their first week of night duty during their third ward and subsequently during allocations to medical, surgical and paediatric wards throughout training.*

* The GNC syllabus 1977 states that student nurses should undergo a minimum of 8 weeks or 320 hours and a maximum of 24 weeks or 960 hours night duty in a three year training. Two reports pointed out that students at City hospital did an excessive amount of night duty, averaging between 1,040 hours (1984) and 1,160 hours (1986).

A student aged 21 and about to take state final examinations articulated the personal cost of long spans of night duty in the following way:

We had lots of fun, but at the same time it's quite tough. And tough that you are restricting yourself: I've clocked up 25 weeks night duty - which is a long time at my age - when perhaps you ought to be gallivanting, you know.

It may be inferred that being on night duty changed the nature of nursing work, and hence the learning material. However, the findings varied depending on students' stage of training, patients' needs, staffing levels and work organisation. Findings related to the nature of the work and night duty only are discussed here. Other aspects of night duty and student learning are discussed in chapter 8.

Discussion with a group of students who had just completed their third ward showed them to be of varied opinions as to the value of night duty and the nature of the work in terms of learning. To some extent this seemed to depend on whether the ward was 'quiet', in that patients were asleep and hence did not require any nursing interventions; or 'busy', requiring nurses to use their initiative. One discussant thought that 'there were so many drug rounds ... that you really get to know the drugs'.

During participant observation, third warders confirmed that the regular participation in drug rounds also meant that they became familiar with the patients' drugs. The students also valued night duty because of the opportunity to 'get to know your patients better'. A finalist looking back over her three years of training recalled her first week of night duty on Eskdale ward:

I hated the whole week of it, but I think I learnt. There were a lot of patients having chemotherapy ... I think we had two deaths that week and it was quite traumatic, but it built up my confidence.

Another finalist also identified her period of night duty on her third ward as a period of learning, particularly when she witnessed a cardiac arrest. She said:

I learnt a lot through it. Until then I was afraid of cardiac arrests. It was also the first one for the third year I was on duty with. The man died. We were both very upset but because I was the first year I was sent to supper, but nobody supported the third year. I learnt from that too that third years still need support.

A first year student similarly perceived the nature of nursing work on night duty as a learning experience:

The ward (surgical) was so busy. We were running round all night ... you were put in situations on your own which you had to cope with as there was no one there to help you. Like this dressing. Someone told me how to do it but I had to go in there by myself and do it, and it was okay. Those sorts of things just build up your confidence. I don't think I could have such busy nights again. I think I could cope with them now.

The nature of the nursing work on night duty was still perceived as stressful but valuable to learning by a student at the beginning of her third year. Six months later she recalled:

I had a busy set of nights on Langdale about the second ward in my third year. That was quite frightening in that we had a lady who ... kept obstructing her breathing, and to begin with I really panicked. But then there was me and a third warder and I thought 'God, if I panic, what will she do?' That was finally sorted out and there was a lot of different things being done, and I thought after that I didn't panic quite so much when the next night she wasn't well again. Although I was concerned, obviously, I wasn't quite so bad.

Although the nature of the work and learning material on night duty was identified as being stressful because of short staffing, emergency situations and patients dying, students built up confidence in themselves and their ability to cope. The fact that students still recalled their first weeks on night duty two years later was indicative of the personal significance of the learning material available during the night.

5.3 The Nature of the Work and the Learning Material on Four Wards: Ward Profiles and Student Views

It was established in sections 5.1 and 5.2 that students at the City hospital were the primary workforce. Hence the nature of their work, and the activities generated from what was medically and functionally wrong with the patients, were their potential learning material.

During participant observation on four wards, the potential and actual learning activities specific to each ward learning environment were documented. They are presented here in the form of four ward profiles. The differences in the sort of activities undertaken by first and third year students, and the perceived and observed learning experiences available to them, are also described.

Participant observation was complemented by additional evidence collected during interviews and discussion, from document analysis, such as patients' records, and from students' responses to open-ended questions on the questionnaire.

The ward profiles provide information which illustrates who the patients were on each of the study wards, according to the nursing work required to meet their needs, and what was to be learnt by nurses in training whilst carrying out this work. Other factors which influenced the caring-learning environment are also briefly outlined. These factors include the geography and facilities on each ward, the level and consistency of the workload measured by the Barr (1967) dependency checklist, and the quality and quantity of staffing levels. The findings yielded from an analysis of Pembrey's (1980) checklist of work problems, filled in by the four ward sisters during interview, are also presented. The checklist was used to identify the nature of the problems experienced by the sisters on different wards.

The findings are used to characterise each ward according to the

medical/technical and/or the basic/affective nature of the learning material generated by the patient population. The ward profiles also serve to contextualise the case study findings in subsequent chapters.

The findings presented in tables 5.1 (patient dependency) and 5.2 (sisters' daily work problems) are discussed in each of the ward profiles below.

Table 5.1

Classification of patient dependency (Barr 1967) during participant observation on four case study wards

WARD	NO. OF BEDS	NO. OF OBSERV- ATIONS	PATIENT DEPENDENCY						TOTAL NO. OF PATIENTS	
			HIGH N	%	MEDIUM N	%	LOW N	%	N	%
Edale	16	10*	46	33.58	69	50.36	22	16.06	137	100
Winder- mere	20	17	47	15.02	244	77.95	22	7.03	313	100
Ronda	23	19	21	5.25	254	63.85	123	30.90	398	100
Kinder	15	21	33	10.89	214	70.63	56	18.48	303	100

* No Barr dependency data were available for days 1, 2, 6, 10, 14 or 15 for the 16 days of the ward study period on Edale ward.

Table 5.2

Problems identified on Pembrey's (1980) checklist of work problems

PROBLEM NO. ON CHECKLIST	WORK PROBLEMS	PROBLEMS IDENTIFIED BY WARD SISTERS ON:			
		EDALE	WINDERMERE	RONDA	KINDER
2	Doctors not giving patients enough explanation	1	1	1	0
4*	Admissions arriving on ward before bed ready	0	1	1	1
5	The design of the ward	1	1	1	0
10	Getting patients' notes or X-rays	1	1	0	1
17	Getting ward equipment/furniture repaired or replaced	1	1	1	0
20*	Interruptions from the 'phone	1	1	1	0
3*	Being unable to complete one job at a time	1	1	0	0
13*	Number of dependent/handicapped patients	1	1	0	0
21	Getting the ward cleaned properly	1	1	0	0
Other problems (7,8*,11,16*,23*,24*) specified on the checklist (see footnote)		1	5	0	0
Grand Total		9	14	5	2

Footnote Other problems identified on the checklist once only:
 (7) Getting conflicting orders from different doctors; (8) Not enough nurses who can supervise or teach; (11) The feeling that you have no one really to turn to for help; (16) Arranging the off duty to give adequate ward cover; (23) The number of separate medical rounds in a day; (24) Interruptions from the nurses.

* Problems associated with low staffing levels/demanding workload.

5.3.1 Edale ward

(a) Ward profile

Edale ward admitted male patients and had an allocation of 14 general medical and two geriatric beds. Many of the patients suffered from endocrine disorders, which was the specialism of one of the consultants. The ward layout comprised a four bedded balcony and a single room off the main ward of 11 beds. There were two day rooms shared with the female ward across the corridor. One was for non-smokers and the other, with television, for smokers. The ward possessed the usual facilities of sluice, toilets, bathrooms (one with hoist) and a treatment room. The sister's office was situated just inside the ward entrance. The general administration of the ward was conducted from the nurses' station situated in the centre of the main ward. As table 5.2 shows, the sister found the ward design a problem.

Edale had the reputation of being a busy acute medical ward, but eight months after participant observation Edale was redesignated as an acute geriatric ward. All the general medical patients were transferred elsewhere in the hospital. Although Edale had only 16 beds it had a patient population with a high dependency. The Barr patient dependency checklist was completed on ten occasions and revealed that, compared with the other study wards, Edale had the highest overall percentage of 'high dependency' patients (see table 5.1). Table 5.3 below shows that patient numbers alone did not necessarily determine the level of dependency in a ward since the same number of patients (i.e. 15) could generate a range of 56.0 to 76.6 hours of care in a 24 hour period. Patient dependency on the ward fluctuated dramatically in that patients could pass from low to high dependency during the course of a shift if they had undergone an invasive investigation such as a renal biopsy.

Table 5.3

Total nursing hours available by patient hours required for 10 days during an 8 week period: Edale ward

DAY AND WEEK OF STUDY		TOTAL NURSING HOURS AVAILABLE IN 24 HOURS		TOTAL PATIENT HOURS REQUIRED	
		NO. OF NURSES	HOURS AVAILABLE	NO. OF PATIENTS	HOURS REQUIRED
3	1	12	85.0	14	68.6
4	2	11	96.5	16	77.3
5	3	14	101.5	16	76.6
7	3	12	91.25	16	72.6
8	4	10	79.0	15	59.3
9	4	10	75.0	16	74.6
11	5	14	106.25	16	96.0
12	5	11	82.0	15	76.6
13	6	10	73.0	14	68.6
16	8	11	86.5	15	56.0

According to the sister, one of the consultants liked to keep his medicine 'very general'. This preference meant that the throughput of patients on the ward could be very swift, with fluctuations in workload, especially related to the care of 'drug users' of which he admitted many. The variety of patients and conditions was at times considerable and they had a wide range of needs.

The following description of the patient population midway in the study period illustrates this point. All 16 beds were occupied at midday. When the researcher completed the Barr dependency rating (day 9, week 4) there were six high, six medium and four low dependency patients. One patient was dying, one patient was a drug user with a tendency to epileptic fits and respiratory arrests, one patient (admitted from a longstay hospital) had multiple pressure sores, one patient was in sickle cell crisis, two elderly patients were confused, and another elderly patient had problems of pain control. The sister told the researcher that the workload on the ward during the study period was 'typical' for Edale ward. Document analysis showed that the age of patients ranged from 17 to 92 years, during the same period.

Edale was one of the first wards in the hospital to use 'internal rotation' of staff to day and night duty. The establishment of staff nurses had been increased to five to allow sufficient trained staff cover throughout 24 hours.

Table 5.4

Total number of trained/untrained staff available in 24 hours for 10 days during an 8 week period: Edale ward

DAY AND WEEK OF STUDY		TRAINED STAFF	UNTRAINED STAFF	TOTAL STAFF	PROPORTION OF UNTRAINED TO TRAINED STAFF
3	1	5	7	12	0.58
4	2	3	8	11	0.73
5	3	6	8	14	0.57
7	3	4	8	12	0.63
8	4	3	7	10	0.70
9	4	3	7	10	0.70
11	5	4	10	14	0.71
12	5	3	8	11	0.73
13	6	3	7	10	0.70
16	8	3	8	11	0.73
TOTAL:		37	78	115	0.68

Analysis of staffing levels, mix and workload for two 24 hour periods on four wards

Tables 5.5, 5.6; 5.9, 5.10; 5.13, 5.14; 5.17 and 5.18 show:

1. Nursing numbers available by grade in 24 hours.
2. Nursing hours available during morning, afternoon, evening and night shift.
3. Nursing hours available per hour for morning, afternoon, evening and night shift.
4. Total nursing hours available in 24 hours.
5. Total patient hours required in 24 hours.

Table 5.5

Day 8, week 4, Edale ward: assessed by staff as 'average' workload and 'average' staffing

SHIFT	GRADE OF STAFF AVAILABLE						NURSING HOURS AVAILABLE BY:		TOTAL PATIENT HOURS REQUIRED IN 24 HRS
	Sr	S/N	3rd	2nd	1st	OTHER*	TOTAL	SHIFT*** HOUR	
Morn.	0	1	2	0	1	0	4	19.0	3.8
Aft.**	1	1	5	0	1	0	8	23.0	6.6
Eve.	1	0	3	0	0	0	4	18.0	3.6
Night	0	1	1	0	0	0	2	19.0	1.73
TOTAL NO. OF STAFF AVAIL. IN 24 HOURS	1	2	6	0	1	0	10	79.0	59.3

* Other - non-permanent/allocated ward staff, e.g. agency staff; 'team' nurses; volunteers.

** The staff on the afternoon shift overlap from both the morning and evening shifts, and therefore they are counted only once, to calculate the actual number of staff available in each grade over a 24 hour period.

*** Formula for working out number of nursing hours available per hour on any shift or part of a shift

Number of hours actually worked times number of persons on duty
divided by
total number of hours of shift's or part of shift's duration.

DURATION OF SHIFT/PART OF SHIFT IN HOURS	ACTUAL HOURS WORKED DURING EACH SHIFT
Morning 07.45 - 12.45 = 5 hours	4.75 hours
Afternoon 12.45 - 16.15 = 3.5 hours	2.75 hours (morning staff) 3 hours (evening staff)
Evening 16.15 - 21.15 = 5 hours	4.5 hours
Night 20.45 - 07.45 = 11 hours	9.5 hours

Table 5.6

Day 11, week 5, Edale ward: assessed by staff as 'very heavy' workload and 'average' staffing

SHIFT	GRADE OF STAFF AVAILABLE						NURSING HOURS AVAILABLE BY:		TOTAL PATIENT HOURS REQUIRED IN 24 HRS
	Sr	S/N	3rd	2nd	1st	OTHER	TOTAL	SHIFT HOUR	
Morn.	1	1	3	0	1	1	7	33.25	6.7
Aft.	1	2	6	0	1	1	11	31.5	9.0
Eve.	0	1	3	0	0	1	5	22.5	4.5
Night	0	1	0	0	1	0	2	19.0	1.73
TOTAL NO. OF STAFF AVAIL. IN 24 HOURS	1	3	6	0	2	2	14	106.25	96.0

Table 5.4 shows that, on the ten days that data on patient dependency and staffing levels were collected, the average proportion of untrained to trained staff was 0.68. This ratio confirms findings in section 5.1, that students constituted approximately two-thirds of the workforce on the wards.

The staffing levels show slight fluctuations, from the limited data available (see tables 5.5 and 5.6). For example, a workload of 59.3 hours of nursing required in 24 hours, and described by the nurse in charge as 'average', yielded the following staff data. During the morning shift there were 3.8 nursing hours available per hour, 6.6 in the afternoon, 3.6 in the evening and 1.73 during the night. When the workload increased to 96.0 hours of care required in 24 hours, and described by the nurse in charge as 'very heavy', the staffing levels also increased to 6.7 nursing hours per hour on the morning shift, 9.0 in the afternoon, 4.5 in the evening, but still only 1.73 nursing hours

per hour during the night. The extra staff hours were accounted for by 'team' nurses.*

For the 56 days covering the study period, irrespective of whether the researcher was on the ward or not, the following information on patient movement was obtained from an analysis of patient records: 72 admissions, 58 discharges, 14 transfers in, 17 transfers out, 49 emergency admissions and 5 deaths. The greater number of emergency than routine admissions appeared to be an important factor affecting the unpredictability of the workload.

The sister identified nine work problems on Pembrey's checklist (table 5.2). Four of these problems were associated with the workload or staffing levels and confirmed the findings yielded from the Barr dependency data.

5.3.1 The nature of the work and the learning material: student views

The nature of the work generated from what was medically and functionally wrong with patients on Edale ward changed throughout the 18 months of data collection at City hospital. This change was reflected by students' comments during interviews at the various stages of the research. For example, at the beginning of data collection, the acute nature of the work was characterised by a senior student thus:

Edale isn't a typical medical ward. There's always something exciting going on there.

A few months later, the following quotation suggests that the patient population on Edale ward was beginning to change:

... initially, I thought there were a lot of old people on there ... but when you think about it most people who are going to have

* 'Team' nurses were second and third year students on 'relief' duties for a short period. They were sent on a daily basis to wards where the staffing levels were low and/or the work load was high. It was likely that these students were unfamiliar with the patients and their needs and less effective than more permanent staff.

medical problems are going to be old anyway, because that's when you start to get problems.

The final comment was made when Edale had become a specialist geriatric ward:

I was amazed at how well the staff had taken it (the change to geriatrics) ... considering that for many years it was an acute ward.

The following accounts based on student interviews, discussions and field observations suggest that students' perceptions of the nature of the work and the learning material changed as they progressed through training.

First warders were more concerned with learning 'basic nursing care', i.e. making beds, bathing patients, talking to them and becoming competent in taking observations such as temperature, pulse, respirations and blood pressures, and also measuring and testing urine. This did not differ significantly from the other case study wards. Specific to Edale ward was the measurement of blood sugar and within a week a first year student was observed to be recording patients' blood sugars on her own. Students also participated in drug rounds and the removal of a 'venflon' (needle for the administration of intravenous drugs) under supervision was mentioned after two days on the ward. The giving of suppositories and injections were also supervised. Again, participation in these activities was not ward specific.

The acute nature of the work at the beginning of data collection meant that students were inevitably on duty when emergencies occurred, such as a respiratory arrest. First warders tended not to actively involve themselves in these emergencies, whereas by the third ward they did. The exposure to emergencies was partly a consequence of being on night duty during this phase of training. Nurse T, for example, commented at the end of her allocation on the frequency of emergencies:

It all happens here. I've really enjoyed the ward and I've learnt such a lot.

Third year students recognised that they learnt about ward management on Edale. Students in module 12 were taking their management assessment, and Nurse K described how:

From day one, sister said 'you're doing your ward management'. She made you examine and think about it and what had to be done. I did learn a lot about the different styles of management and how stressful it is to manage a ward.

After the change of specialty to acute geriatric medicine, a module 14 student still maintained that she 'benefited most from management' experience while on Edale ward.

5.3.2 Windermere ward

(a) Ward profile

Windermere ward was a 20 bedded female ward. 18 of the beds were allocated to general medical and 2 to geriatric patients. However, apart from a predominance of patients with respiratory disorders, which were the professor of medicine's specialist interest, the age and dependency of the general medical and geriatric patients were hardly distinguishable. Windermere had a reputation in the hospital as a 'heavy' ward, demanding hard physical work.

The ward had been modified from a Nightingale layout and was divided into bays down one side. There were three bays with 4 beds and one with 2 beds. The remaining 6 beds were organised in a line down one side of the ward. There were no single rooms. There was a recently refurbished dayroom with television. Although pleasantly decorated, it was very small and shared with the men's ward across the corridor. Ambulant patients frequently went to sit on the outside landings, especially if they wanted to smoke.

Windermere had a sluice, toilets, bathrooms - one with hoist - and a treatment room. The sister's office was just outside the ward entrance. The general administration of the ward was conducted from the centrally situated nurses' station. The sister identified ward design as a work

problem (table 5.2).

The workload on Windermere ward was heavy and unpredictable. Table 5.1 reveals that Windermere ward had the lowest percentage (7.03%) of patients in the low dependency category. Document analysis suggested that the unpredictability could be related to a high percentage of emergency admissions (54 %) and crises arising from the unpredictable behaviour of demented elderly ladies. During the study period, geriatric patients were 'lodging' from another ward, which was closed for redecoration. Thus, the number of designated geriatric patients increased. There were also a number of surgical patients either admitted with an underlying medical condition or admitted to Windermere because there were no beds on the surgical wards at the time of emergency admission.

During the study period, as shown in table 5.7, on 17 occasions bed occupancy was between 13 and 20 patients, requiring a range of 56.6 to 96.0 hours of care in 24 hours, respectively. Document analysis revealed that their ages ranged from 22 to 95 years, with approximately 72% who were 65 years and over, one third of whom were over 80. These statistics confirm Windermere's reputation as a ward with an elderly patient population and a heavy workload.

There had been a shortage of trained staff on Windermere ward and it was only at the beginning of the study period that their numbers had increased from 2 to 5.

Table 5.8 shows that, as on other wards, the students usually constituted at least two-thirds of the workforce.

An analysis of the staffing levels on the Barr dependency checklist (see tables 5.9, 5.10) shows a relative unevenness in relation to workload; also, on one occasion, a reliance on 'team' nurses to keep the numbers at satisfactory levels.

Table 5.7

Total nursing hours available by patient hours required for
17 days during an 8 week period: Windermere ward

DAY AND WEEK OF STUDY		TOTAL NURSING HOURS AVAILABLE IN 24 HOURS		TOTAL PATIENT HOURS REQUIRED	
		NO. OF NURSES	HOURS AVAILABLE	NO. OF PATIENTS	HOURS REQUIRED
1	1	11	91.5	17	88.0
2	1	14	94.25	20	96.0
3	2	17	95.0	19	96.0
4	2	16	106.5	20	89.3
5	2	13	92.5	20	89.3
6	3	12	94.0	20	64.0
7	4	12	94.0	13	56.6
8	4	11	86.5	13	56.6
9	4	13	101.5	20	82.0
10	5	10	75.5	18	88.6
11	5	9	71.5	20	92.6
12	6	10	79.0	18	68.6
13	6	12	84.0	19	84.0
14	6	10	76.0	20	80.6
15	7	15	114.0	18	73.3
16	8	10	76.5	20	84.0
17	8	11	81.5	20	84.6

Table 5.8

Total number of trained/untrained staff available in 24 hours
for 17 days during an 8 week period: Windermere ward

DAY AND WEEK OF STUDY		TRAINED STAFF	UNTRAINED STAFF	TOTAL STAFF	PROPORTION OF UNTRAINED TO TRAINED STAFF
1	1	2	9	11	0.82
2	1	2	12	14	0.86
3	2	5	12	17	0.71
4	2	5	11	16	0.69
5	2	5	8	13	0.62
6	3	4	8	12	0.66
7	4	4	8	12	0.66
8	4	4	7	11	0.64
9	4	4	9	13	0.69
10	5	3	7	10	0.70
11	5	6	3	9	0.33
12	6	3	7	10	0.70
13	6	5	7	12	0.58
14	6	6	4	10	0.40
15	7	5	10	15	0.66
16	8	3	7	10	0.70
17	8	3	8	11	0.73
TOTAL:		69	137	206	0.67

Table 5.9

Day 8, week 4, Windermere ward: assessed by staff as 'average' workload and 'average' staffing

SHIFT	GRADE OF STAFF AVAILABLE							NURSING HOURS AVAILABLE BY:		TOTAL PATIENT HOURS REQUIRED IN 24 HRS
	Sr	S/N	3rd	2nd	1st	OTHER	TOTAL	SHIFT	HOURL	
Morn.	1	1	2	0	1	1	6	28.5	5.7	
Aft.	1	2	3	0	2	1	9	25.5	7.3	
Eve.	0	1	1	0	1	0	3	13.5	2.7	
Night	0	1	0	0	1	0	2	19.0	1.73	
<hr/>										
TOTAL NO. OF STAFF AVAIL. IN 24 HOURS	1	3	3	0	3	1	11	86.5		56.6

Table 5.10

Day 2, week 1, Windermere ward: assessed by staff as 'heavy' workload and 'low' staffing

SHIFT	GRADE OF STAFF AVAILABLE							NURSING HOURS AVAILABLE BY:		TOTAL PATIENT HOURS REQUIRED IN 24 HRS
	Sr	S/N	3rd	2nd	1st	OTHER	TOTAL	SHIFT	HOURS	
Morn.	0	1	1	1	2	1	6	28.5	5.7	
Aft.	0	2	2	0	3	2*	8*	24.5	6.9	
Eve.	0	1	2	0	1	1	5	22.5	4.5	
Night	0	0	1	0	1	0	2	19.0	1.73	
<hr/>										
TOTAL NO. OF STAFF AVAIL. IN 24 HOURS	0	2	4	1	4	3*	14*	94.25		96.0

* 'Team' nurse stayed for 1 hour during the afternoon; counts as one extra nurse in total.

An unusually quiet weekend and described as 'average' on the Barr dependency rating yielded the following data: workload (56.6 hours of care required in 24) with 5.7 nursing hours available per hour on the morning shift, 7.3 in the afternoon, but only 2.7 and 1.73 nursing hours available per hour on the evening and night shifts respectively. However, these data are comparable to the other study wards for

'average' days. There were no 'team' nurses on these shifts. When the workload rose to 96.0 hours of care required in 24, described by the nurse in charge as 'heavy', there was no significant increase in staff except on the evening shift (4.5 nursing hours per hour). The hours of nursing time available included extra help from 'team' nurses.

For the 56 days covering the ward study period irrespective of whether the researcher was on duty or not, the following information on patient movement was obtained during document analysis: 55 admissions, 51 discharges, 14 transfers in and 11 out, 27 emergency admissions and 4 deaths. 5 admissions were unclassified.

The sister on Windermere ward identified the highest number of work problems of all four ward sisters, on the Pembrey checklist (table 5.2). Seven of the 14 problems were associated with the workload/staffing levels on the ward and confirm Windermere's reputation as a heavy, physically demanding ward and the findings yielded from the Barr dependency data. Of particular interest was her identification of problem (8), which stated that there were 'not enough nurses to teach and supervise' on the ward. It could be interpreted that although Sister Windermere had more problems than other sisters in staffing and running her ward, given the workload, she was also less reticent in declaring her problems than her colleagues.

(b) The nature of the work and the learning material: student views

The nature of the work on Windermere ward changed two thirds of the way through the eighteen month period of data collection at City hospital. A module 12 student wrote in her questionnaire:

We started admitting patients under several new consultants and we 'lost' our geriatric patients. I do not feel that the ward or staff was adequately prepared for this change, as it meant we were nursing acute patients such as unstable diabetics rather than rehabilitating geriatrics.

This comment shows that although Windermere ward was a designated general medical ward with only two beds for geriatric patients it was

primarily seen as a ward for elderly dependent patients, i.e. a geriatric ward, until the change of consultants.

A first warder confirmed the original view of Windermere as a geriatric ward when she said:

There have been very few patients who could take care of themselves, so you were always doing bowels and commodes and that sort of thing.

Students' changing views of the nature of the work and the learning material during their first and third year of training are described below.

First ward students described taking observations such as temperature, pulse, respiration and blood pressure as learning experiences. Two first warders' questionnaire comments sum up the general view of the learning material on Windermere as:

... ideal for a first ward, as there is only very basic nursing care, i.e. communicating to patients and other staff, bed bathing etc., to be learnt, the best grounding anyone could receive for future careers.

Apparently quite heavy for a first ward, so good experience of hard work. Bed baths became boring after about a week! But valuable experience!

By the time students reached the third ward they no longer saw much learning value in carrying out so-called 'basic nursing'. One student wrote in her questionnaire that being on the ward: 'only taught me how to do a lot of work quickly' and that she did 'not believe that Windermere can be called a teaching ward'.

The types of emergency that students were subject to on Windermere ward were related to trained staff shortages and unpredictable workload. For example, during interview, two first warders described an evening when they were on the ward with two third year students. No trained staff were on duty. A patient was admitted as an emergency, suffering from a stroke from which she later died. Another patient, who was demented, crashed into the radiator whilst the students were attending other patients. The atmosphere 'got nasty', according to the

first warders, but they agreed that they had felt 'at a bit of a spare end; there wasn't a lot we could do'. Like the first warders on Edale ward they had decided not to involve themselves actively in an emergency, because of their inexperience.

A student who had been on Windermere ward during module 12 of the third year assessed the learning potential as:

... pretty good ... it's another ward (like Edale) that nobody likes going to ... but you get out as much as you put in, probably more.

Another student at the same stage of training did not think that she 'learnt an awful lot up there really', although when pressed she admitted:

Sister let me do a lot which was really good experience, like (arranging) district nurses and social workers, organising transport and discharging people ... and also third years teaching the first years; that was good experience for me.

Other third year students clearly did not like the ward because they did not like 'basic nursing care' and they disagreed with the sister's commitment to the nursing process and her emphasis on talking to patients in preference to completing all the physical tasks during the morning shift (elaborated in section 6.3.2(c)).

Students at all stages of training judged the sister's commitment to the nursing process and her work priorities as impractical because of the heavy physical workload. One student gave a representative view when she said:

On Windermere ward they are certainly pro the nursing process. I found sister added to stress there because of the time she took. Her philosophy was good but it's really difficult to meet the balance where the work gets done ... we were really pushed.

When patients required 'technical' nursing such as care of intravenous infusions and chest drains, a first warder commented that the third year students 'automatically take charge, because there are so few things like that'. The researcher confirmed the first warder's comment during participant observation.

5.3.3 Ronda ward

(a) Ward profile

Ronda ward was one of the larger wards in the hospital, with a total of 23 beds. It was also geographically complex, comprising 4 side wards (2 of which were single rooms), a 4 bedded balcony, and the main ward accommodating 12 patients. There was a small shabby dayroom with television, a sluice with new bed pan washer, toilets, 2 bathrooms and a treatment room. The sister's office was situated in the middle of the complex, down a short corridor past the linen cupboard, giving the impression of being tucked away in a corner. The general administration of the ward was conducted from the nurses' station in the 12 bedded ward. The sister identified the ward design as a work problem on Pembrey's checklist, as shown in table 5.2.

Ronda was one of four wards comprising the gastroenterology unit and, although predominantly a male ward, could take female patients in the side wards. The single rooms were mostly used for patients undergoing chemotherapy for leukaemia or lymphomas and requiring protective isolation. They were also occasionally used for patients with infectious diseases (including patients suffering from autoimmune deficiency syndrome).

The ward served the gastroenterology unit, headed by a consultant who was a specialist in using endoscopic retrograde cholangio-pancreatography (ERCP) for diagnosing and treating diseases of the common bile duct. The ERCP could be used as an alternative to major surgery for removing gallstones and bypassing often malignant tumours in the common bile duct, by the insertion of a stent. Young patients with pancreatitis were often admitted, requiring parenteral nutrition as part of their preparation for surgery.

There were also 8 geriatric beds containing some elderly patients who were waiting for transfer to the longstay geriatric hospital. Thus

the ward provided a variety of nursing work, from the acute care required by the gastroenterological and haematological patients to the highly dependent elderly. In addition, many of the patients and their relatives required considerable psychological support because of the nature of their diagnosis and uncertain prognosis. Those in protective isolation, for example, could be enclosed in a small room for up to six weeks.

In some instances patients would return to the ward in the final stages of their illness when all attempts at treatment had failed. Skilful pain control was required, not only for these dying patients but also for those suffering from the excruciating pain of pancreatitis and cholecystitis.

Table 5.11

Total nursing hours available by patient hours required for 19 days during an 8 week period: Ronda ward

DAY AND WEEK OF STUDY		TOTAL NURSING HOURS AVAILABLE IN 24 HOURS		TOTAL PATIENT HOURS REQUIRED	
		NO. OF NURSES	HOURS AVAILABLE	NO. OF PATIENTS	HOURS REQUIRED
1	1	12	91.5	17	58.6
2	1	12	84	17	51.3
3	2	11	84	21	74.6
4	2	13	94	23	80.6
5	2	13	89	23	79.3
6	3	13	87.75	21	59.3
7	3	13	89.5	16	51.3
8	4	11	81.5	22	68.0
9	4	13	99	23	62.6
10	5	12	89	22	78.6
11	5	11	81.5	23	73.3
12	6	11	81.5	23	66.0
13	6	11	84	23	65.3
14	6	12	94	22	85.3
15	7	10	71	19	62.6
16	7	9	67.5	19	59.3
17	8	11	86.5	22	61.3
18	8	11	81.5	23	66.6
19	8	11	84	22	73.3

Although Ronda ward had the highest number of beds of the four study wards, it did not have the highest dependency. Table 5.1 (p.247) shows that Ronda ward had the lowest and highest percentage of patients in the high and low dependency categories respectively, for the four study wards. Table 5.11 reveals that bed occupancy varied on 19 occasions, from 16 to 23 patients requiring a range of 51.3 to 85.3 hours of care in 24 (compare Edale ward, with a range of 14 to 16 patients requiring 56.0 to 96.0 hours of care in 24).

However, patient dependency on the ward was observed to fluctuate in that patients could pass from low to high dependency during the course of a shift if they had undergone an invasive investigation, such as a liver biopsy or ERCP. Some patients were able to go home on weekend leave, which lightened the workload as their beds were guaranteed to remain empty until their return.

The age range of patients varied considerably. The following information was extracted from document analysis for the period that the researcher was on the ward (56 days). The age range was 19 to 90 years, with just over half the population below 65 years. Very few patients were over 80 years. Compared with the other study wards, the patient population of Ronda ward was comparatively 'young'.

Because of the layout and size of the ward, the sister had negotiated a designated senior staff nurse post. She therefore had an establishment of 6 trained staff (additional to herself) compared with 5 on other wards. The average proportion of untrained to trained staff on Ronda ward was only slightly lower than on other wards despite the appointment of an extra staff nurse (table 5.12).

The sister planned the off-duty rota to take account of predictable fluctuations in the workload, such as days when there was an influx of booked admissions or when ERCPs were planned. The staffing levels (tables 5.13 and 5.14) show a relative unevenness during the day and

evening shifts, which is reflected in the nursing hours available per hour. An 'average' day in terms of workload (59.3 hours of care required in 24) yielded the following staff data. During the morning shift there were 5.7 nursing hours available per hour, 5.1 in the afternoon, 4.5 in the evening, but only 1.73 during the night. For 4 of the 11 hours, one nurse was on her own in the main ward with responsibility for patients in the outlying side wards also.

Although patients in the side wards had a call system and might not be acutely ill, they were often receiving intravenous infusions that required monitoring. The sister was aware of the problem and was currently negotiating an extra permanent staff member for night duty.

Table 5.12

Total number of trained/untrained staff available in 24 hours for 19 days during an 8 week period: Ronda ward

DAY AND WEEK OF STUDY		TRAINED STAFF	UNTRAINED STAFF	TOTAL STAFF	PROPORTION OF UNTRAINED TO TRAINED STAFF
1	1	3	9	12	0.75
2	1	3	9	12	0.75
3	2	5	6	11	0.55
4	2	7	6	13	0.46
5	2	4	9	13	0.69
6	3	6	7	13	0.54
7	3	6	7	13	0.54
8	4	4	7	11	0.64
9	4	5	8	13	0.62
10	5	3	9	12	0.75
11	5	5	6	11	0.55
12	6	3	8	11	0.73
13	6	4	7	11	0.64
14	6	5	7	12	0.58
15	7	4	6	10	0.60
16	7	4	5	9	0.55
17	8	5	6	11	0.55
18	8	4	7	11	0.64
19	8	6	5	11	0.45
TOTAL:		86	134	220	0.61

Table 5.13

Day 6, week 3, Ronda ward: assessed by staff as 'average' workload and 'average' staffing

SHIFT	GRADE OF STAFF AVAILABLE							NURSING HOURS AVAILABLE BY:		TOTAL PATIENT HOURS REQUIRED IN 24 HRS
	Sr	S/N	3rd	2nd	1st	OTHER	TOTAL	SHIFT	HOURL	
Morn.	0	3	3	0	0	0	6	28.5	5.7	
Aft.	1	1	2	0	2	0	6	17.75	5.1	
Eve.	1	1	1	0	2	0	5	22.5	4.5	
Night	0	1	1	0	0	0	2	19.0	1.73	
TOTAL NO. OF STAFF AVAIL. IN 24 HOURS	1	5	5	0	2	0	13	87.75		59.3

Table 5.14

Day 14, week 6, Ronda ward: assessed by staff as 'high' workload and 'low' staffing

SHIFT	GRADE OF STAFF AVAILABLE							NURSING HOURS AVAILABLE BY:		TOTAL PATIENT HOURS REQUIRED IN 24 HRS
	Sr	S/N	3rd	2nd	1st	OTHER	TOTAL	SHIFT	HOURL	
Morn.	0	2	2	0	1	0	5	23.75	4.75	
Aft.	0	4	3	0	2	0	9	25.75	6.8	
Eve.	0	2	1	0	1	0	4	18.0	3.6	
Night	0	1	0	0	1	1	3	26.5	2.4	
TOTAL NO. OF STAFF AVAIL. IN 24 HOURS	0	5	3	0	3	1	12	94.0		85.3

On the day assessed as having a 'high' workload (85.3 patient hours required in 24), for example, the nursing hours available per hour at night increased because an agency auxiliary nurse joined the staff in response to the senior staff nurse's request to the nursing administration department for help. However, for the morning, afternoon and evening shifts, nursing hours available per hour were

less on the day described as having a 'heavy' workload than on the day with the 'average' workload. The reason for the inconsistency in matching staffing levels to workload appeared to lie in the increased number of patients who were acutely ill on the ward on day 14 of the researcher's period on the ward. With the occasional exception of night duty, there was usually more than one trained member of staff on duty and a balance between senior and junior learners.

An analysis of patient records for the 56 days covering the study period on the ward, irrespective of whether the researcher was on duty or not, yielded the following information on patient movement: 108 admissions, 109 discharges, 23 transfers in, 16 transfers out, 28 emergency admissions and 8 deaths.

Although the ward had a high turnover of patients, the majority of them were routine admissions which appeared to be an important factor in predicting the workload. However, the arrival of admissions on the ward before a bed was ready was identified by the sister as a work problem on Pembrey's checklist (table 5.2). The total number of problems, identified at five, was the second to lowest amongst the four ward sisters, and confirmed the findings yielded from the Barr dependency data.

(b) The nature of the work and the learning material: students' views

The nature of the work on Ronda ward was consistent throughout the 18 month period of data collection at City hospital, in that the specialty remained the same although there were changes of consultants. Ronda ward was known as a gastroenterology ward and first year students associated it with this specialty. However, many of the patients were suffering from underlying malignancies. It is interesting that a third warder said: 'In the school week we learnt a lot about cancer, but there are not many patients with cancer here' (see also chapter 4, section 4.2.3).

A third year student (module 14), on the other hand, described Ronda as 'an oncology ward, more or less'. These two students were on the ward within a month of each other. As on the other wards, it was observed that what students learnt and what they prioritised as learning material depended on their stage of training.

A first warder's questionnaire comment gives a representative view of what first warders said they learnt on Ronda ward:

... basic nursing care and the general routine ... basic observations and relations with patients.

During interview a module one student said that she had also learnt how to feed patients, bandaging techniques and removal of a 'venflon' needle.

By the time students had come to their third ward they were mentioning on their questionnaires that they found nursing patients in 'protective isolation' and visiting the endoscopy unit valuable for their education. Similarly, third year students mentioned these experiences (nursing patients in protective isolation and observing endoscopies) as valuable for their education. Third year students also wrote that they found the teaching and management opportunities provided by trained staff of educational value.

On one first warder's first full day on Ronda, there was a staff shortage. Although she was paired to work with a third year student, the researcher was asked to work with the first warder. It was observed that the first year and the researcher were left to care for the dependent patients, whilst the third year got on with the more 'technical' aspects of the job, i.e. the four hourly observations, taking a patient to theatre, checking a patient's dressing and looking after the patient in protective isolation.

As was observed on Windermere ward, the third year students

concentrated on the technical tasks for their allocated patients, leaving first year students to carry on with the so-called 'basic' care.

5.3.4 Kinder ward

(a) Ward profile

Kinder ward was one of the smaller wards in the hospital, with a total of 15 female beds. There was also a 3 bedded coronary care unit attached to the ward, for which the sister and the trained staff had responsibility. The ward had been modified from a 'Nightingale' layout and was divided into bays down one side. There were two bays with 4 beds and one with 2 beds. The remaining 6 beds were organised in a line down the other side of the ward. There were no single rooms or dayroom. A television was situated in the middle bay, high up on the wall and rarely used. Patients either sat by their beds or went to sit on the outside landing. The ward had the other facilities of sluice, toilets, bathrooms (one with hoist) and a treatment room. The sister's office was situated just outside the ward entrance. The general administration of the ward was conducted from the nurses' station close to the ward entrance and opposite the coronary care unit. As table 5.2 shows, the sister on Kinder ward was the only one of the four sisters under study who did not identify ward design as a work problem.

Kinder was one of four wards comprising the cardiovascular unit. Patients were admitted with cardiac conditions usually as routine admissions for investigations, which included cardiac catheterisation. Subsequently they could be admitted for preparation for insertion of pacemakers or for open-heart surgery such as coronary artery bypass graft (CABG), commonly referred to as 'cabbage'. There was close liaison between the ward staff and the intensive care unit situated

next door, since patients were admitted there immediately following surgery. The preoperative routine included taking patients to the unit so that they would be familiar with their surroundings on regaining consciousness. The ward also had designated beds for four general medical and two geriatric patients.

Administratively, Kinder was always busy because of having routine admissions most days, but the workload was predictable. The sister also had control over transferring patients from the coronary care unit to the main ward. The existence of the unit on the ward meant that acutely ill cardiac patients were not usually on the 'open' ward.

However, because the majority of patients were suffering from cardiac conditions, there was an awareness by staff and patients that an emergency situation such as cardiac arrest could arise at any time. The ward therefore was associated with high technology care and a rapid but predictable turnover of relatively independent patients.

Psychological care for patients undergoing cardiac investigations and surgery was recognised as an integral part of their care. The ward had an efficient and calm atmosphere which appeared to keep both nurses' and patients' potential anxiety under control. The dominant orientation of the ward was towards the care of patients with cardiac conditions.

During the ward study period the situation changed, to some extent. The bed allocation was changing in the hospital generally. As mentioned, geriatric patients were being centralised on two wards and during the transition some wards found their numbers of geriatric patients actually increased until beds became available for them on the specialist wards. This situation occurred on Kinder ward, increasing the number of geriatric patients to four. There was also a threat of

bed closures, and the sister thought that consultants were keeping their beds occupied as well as increasing the throughput of patients, in order to make a case for the number of beds they required. The sister felt that the combined effects of actual and potential changes had affected the nature of the nursing work by increasing the workload. Not only had the number of admissions increased, in her opinion, but also the type of patients had changed; they were more dependent and required more basic than technical care.

Kinder ward had a reputation for having a light workload. Barr dependency data confirmed this to some extent (see table 5.15). Hours of care required in 24 showed a range of 36.0 to 72.6 hours, representing 13 to 15 patients respectively on 21 occasions. The researcher observed that patients' dependency could pass from low to high during the course of a shift if they had undergone an invasive investigation such as a cardiac catheterisation or had had a pacemaker inserted.

Analysis of patient records showed that age varied considerably during the study period, with a range of 17 to 94 years. A breakdown of data during document analysis showed that approximately 71% of the patient population was over 65 years. This seemed to confirm the sister's impression that the nature of the work had changed. Indeed, an analysis of the admission statistics during a 4 month period including the ward study period show that 40.94% of all admissions were 65 years and over, with a peaking to 69.44% during the first month of the research.

Table 5.15

Total nursing hours available by patient hours required for
21 days during an 8 week period: Kinder ward

DAY AND WEEK OF STUDY		TOTAL NURSING HOURS AVAILABLE IN 24 HOURS		TOTAL PATIENT HOURS REQUIRED	
		NO. OF NURSES	HOURS AVAILABLE	NO. OF PATIENTS	HOURS REQUIRED
1	1	10	76.5	13	42.6
2	1	10	79.0	15	43.3
3	1	8	61.5	13	38.6
4	2	13	101.5	13	38.6
5	2	11	84.0	14	36.0
6	2	11	81.5	15	50.6
7	3	11	83.75	15	66.0
8	3	9	69.0	12	52.6
9	3	9	71.0	14	68.6
10	4	14	100.75	15	72.6
11	4	12	94.0	15	58.0
12	5	10	74.0	15	66.6
13	5	10	79.0	15	58.0
14	6	10	76.5	15	61.3
15	6	9	71.5	14	58.0
16	7	9	71.5	15	65.0
17	7	10	74.0	15	54.0
18	7	9	69.0	15	60.6
19	8	8	61.5	15	60.6
20	8	11	86.5	15	57.3
21	8	10	74.0	15	57.3

The patient population on Kinder ward whilst the researcher was on the ward was probably not typical. This was certainly the opinion of the trained staff. However, it illustrates the importance of considering the effects of external forces on the caring-learning environment of the ward.

The trained staff establishment was higher than on some wards because of the existence of the coronary care unit. There were eight staff nurses as well as a vacancy for a night staff nurse. The sister planned the off-duty rota well in advance. However, because of the vacancy and the need to have trained staff in the unit at all times, the main ward was staffed predominantly by students on nights and at the weekend. Consequently, as illustrated by the findings presented in

Table 5.16

Total number of trained/untrained staff available in
24 hours for 21 days during an 8 week period:
Kinder ward

DAY AND WEEK OF STUDY		TRAINED STAFF	UNTRAINED STAFF	TOTAL STAFF	PROPORTION OF UNTRAINED TO TRAINED STAFF
1	1	3	7	10	0.70
2	1	2	8	10	0.80
3	1	0	8	8	1.00
4	2	2	11	13	0.85
5	2	3	8	11	0.73
6	2	4	7	11	0.64
7	3	3	8	11	0.73
8	3	2	7	9	0.77
9	3	2	7	9	0.77
10	4	5	9	14	0.64
11	4	4	8	12	0.66
12	5	3	7	10	0.70
13	5	3	7	10	0.70
14	6	2	8	10	0.80
15	6	3	6	9	0.66
16	7	4	5	9	0.55
17	7	3	7	10	0.70
18	7	2	7	9	0.77
19	8	2	6	8	0.75
20	8	4	7	11	0.64
21	8	3	7	10	0.70
TOTAL:		59	155	214	0.72

table 5.16, the average proportion of untrained to trained staff on Kinder ward was higher at 0.72 than on the other study wards.

An 'average' day in terms of workload (57.3 hours of care required in 24) yields the following staff data. During the morning shift there were 5.7 nurses per hour, 7.3 in the afternoon, but only 2.7 in the evening and 1.73 during the night (table 5.17).

When the workload was described as 'heavy' by the nurse in charge, there was an increase in staff hours available per hour for the morning and the evening shifts at 6.65 and 4.5 respectively (table 5.18). The reason for the increase in staff on that day was that there were no patients in the CCU. Trained staff were temporarily released to work in

the main ward. Usually two student nurses staffed the main ward at night but because of the staff nurse vacancy there were a number of occasions when a student was working with an agency nurse, which the third warders could find particularly stressful. The availability of the unit staff nurse alleviated this stress slightly.

Table 5.17

Day 20, week 8, Kinder ward: assessed by staff as 'average' workload and 'average' staffing

SHIFT	GRADE OF STAFF AVAILABLE							NURSING HOURS AVAILABLE BY:		TOTAL PATIENT HOURS REQUIRED IN 24 HRS
	Sr	S/N	3rd	2nd	1st	OTHER	TOTAL	SHIFT	HOURL	
Morn.	1	1	2	2	0	0	6	28.5	5.70	
Aft.	1	2	3	2	1	0	9	25.5	7.30	
Eve.	0	1	1	0	1	0	3	13.5	2.70	
Night	0	0	1	0	0	1	2	19.0	1.73	
<hr/>										
TOTAL NO. OF STAFF*	1	2	4	2	1	1	11	86.5		57.3

Table 5.18

Day 10, week 4, Kinder ward: assessed by staff as 'high' workload and 'average' staffing

SHIFT	GRADE OF STAFF AVAILABLE							NURSING HOURS AVAILABLE BY:		TOTAL PATIENT HOURS REQUIRED IN 24 HRS
	Sr	S/N	3rd	2nd	1st	OTHER	TOTAL	SHIFT	HOURL	
Morn.	1	3	3	0	0	0	7	33.25	6.65	
Aft.	1	2	4	1	1	0	9	26.06	7.43	
Eve.	0	1	2	1	1	0	5	22.5	4.5	
Night	0	0	1	0	1	0	2	19.0	1.73	
<hr/>										
TOTAL NO. OF STAFF*	1	4	6	1	2	0	14	100.75		72.6

* Total number of staff available in 24 hours.

Document analysis for the 56 days covering the ward study period irrespective of whether the researcher was on duty or not yielded the following information on patient movement: 46 admissions, 44 discharges, 10 transfers in and 9 transfers out, 8 emergency admissions and 2 deaths.

That the majority of the admissions were routine appeared to be an important factor in predicting the workload and planning the off-duty rota to provide adequate staffing levels when needed. However, as table 5.2 shows, patients arriving on the ward for admission before a bed was ready was one of only two problems identified on Pembrey's checklist by the sister. Indeed, Sister Kinder identified the fewest work problems of the four sisters under study. This finding appeared to confirm both Kinder's reputation as a relatively 'quiet' ward and the findings yielded from the Barr dependency data. The sister took advantage of the staff overlap in the afternoon for teaching purposes.

(b) The nature of the work and the learning material: students' views

The nature of the work changed on Kinder ward twice during the 18 month study period at City hospital, and was associated with an increase in geriatric patients. The first change occurred some months before the researcher was on Kinder ward, when one of the other medical wards was closed for refurbishing. The second change coincided with participant observation. In the two months leading up to the researcher's time on the ward a third warder described the majority of patients as 'in for tests ... they were all normal people and they weren't too worried or anything'.

Nurse K who was on the ward at the same time as the researcher said 'it was very busy at times'. This observation was an interesting challenge to Kinder ward's reputation as being a 'quiet' ward. K also described it as a good ward for student learning because the patients 'had a high dependency ... and it was a very general medical ward as well'.

Students' perceptions of the nature of the work and learning material varied according to their stage of training, as illustrated by the following accounts. Although first warders were concerned as on other wards that they should learn the basic skills of making beds, bathing patients and talking to them, there was some evidence to suggest that

they were exposed earlier to the more technical aspects of care. First warders who were on Kinder ward a year prior to the researcher described their work as washes, observations and helping with lifts. One student was shown by the sister how to remove stitches from a cardiac catheterisation site. T, who was on the ward six months before the researcher, described her work on Kinder ward in the following way:

For a while I was just doing normal things ... like making beds; then I'd watch people doing things, things that looked so hard looking so easy, like suppositories, giving injections.

A first warder, on the ward at the same time as the researcher, said:

I do love it when you have time for the patients. I really enjoy it ... I get frustrated when there isn't time, time to sit and chat. I do like sitting there, but I always feel as if I should be doing things.

The questionnaire comments showed that both first and third warders identified watching investigations, such as cardiac catheterisation, as valuable for their education. However, a third warder who was interviewed just before the researcher went on the ward did not think she had learnt any new skills. She had, though, been able to consolidate pre and post operative care for patients going for cardiac catheterisation and felt that she could now cope with patients suffering from heart disease. Although she had been shown the equipment used in the coronary care unit for resuscitation after cardiac arrest and cardiac monitoring, she described it as 'quite interesting, but you can't really do it'.

As on other wards, third year students on Kinder appreciated the opportunity to gain management and teaching experience. However, they had some reservations, during module 12. The questionnaire comments revealed that they did not like being left in charge of the ward nor relieving trained staff in the coronary care unit.

One student gave a representative view when she wrote that she did not feel she had enough knowledge, given the technical nature of the

work, to be left in charge. A more senior student (module 14), however, saw 'running the ward on weekends on occasions' as valuable to her education.

5.3.5 Characterisation of the four study wards according to the nature of the work and learning material

Barr dependency data

Barr dependency data revealed that high patient numbers did not necessarily equate with high dependency levels (number of patient hours required during a 24 hour period) on a ward. Even though Ronda was the largest of the four study wards, it did not have the highest overall patient dependency. In the first half of the 18 months of data collection at City hospital, the patient dependency and associated workload on both Edale and Windermere were high for different reasons. On Edale the workload appeared to be high because of the acute nature of the patients' conditions, which generated emergency situations (reflected in a higher percentage of patients in the high dependency category than on the other wards). On Windermere and later on Edale, after the latter became an acute geriatric ward, the high dependency was generated from elderly physically and sometimes mentally dependent patients, requiring 'basic' nursing and physical care. As discussed in chapter 2, section 2.1.2, the Barr dependency checklist was originally developed to assess the dependency of acute medical and surgical patients. It was observed, during participant observation, that the categories on the Barr checklist which dealt with physical and 'mental function' or affective needs were not sufficiently sensitive to reflect the degree of dependency generated by patients who required assistance with the activities of living and little or no technical care.

On all four study wards, the average proportion of untrained to trained staff was approximately 0.66 or two-thirds of the workforce (range: 0.61 - 0.72), confirming the view that students constituted the major part of the workforce.

The breakdown of data for days assessed by the nurse in charge as having an 'average' or 'high' workload appeared to bear some relationship to the number of patient hours required in a 24 hour period as calculated from the Barr dependency checklist. The highest workload recorded by the researcher was the day on which staff 'subjectively' assessed the workload as 'high', and 'very high' on Edale ward. The workloads, as calculated from the Barr dependency checklist, were also similar on a range of 56.6 - 59.3 patient hours required in a 24 hour period on all four wards for a workload assessed by the nurse in charge as 'average'.

However, staff perception of 'average' staffing for 'average' workload suggested that nursing hours available exceeded patient hours required by between 19.7 and 29.9 hours. With the exception of Windermere when the workload was higher than the staff available on 7 occasions, dependency and staffing data on all wards showed the nursing hours to be equal or in excess of patient hours required.

It is possible that staffing hours appeared to be in excess of patient hours required because of the crudeness of the Barr dependency checklist. Consequently, the checklist underestimated the hours of patient care required in each dependency category.

Furthermore it was shown that although staffing levels might be maintained during the morning and afternoon, the levels on the evening and night shifts were often inadequate. The organisation of staffing levels to reduce nursing hours available in the evening and during the night was based on the assumption that patients needed less care during these periods, because their treatments were over and they were likely to be resting or sleeping. Participant observation revealed that this was not the case, especially on wards and shifts where the overall dependency of the patients was high. For example patients in the acute phase of illness and elderly dependent patients required similar

amounts of nursing time throughout the day and night. Old people frequently became disorientated and incontinent during the night (Windermere and Kinder wards) and required constant attention. Similarly, acutely ill patients such as those subject to epileptic fits, respiratory arrests, diabetic instability and asthmatic attacks (Edale and Ronda wards) needed comparable levels of surveillance in 24 hours.

Although the dependency data are based on a limited sample (see table 5.1), the breakdown of staffing levels on specific days reveals that, when the four study wards are considered together, the third year students were in numerical terms, the mainstay of the nursing workforce. These findings are confirmed in chapter 7, section 7.2.1(a), which analyses the 'structure' for care during the QualPacs observation sessions.

The findings presented in table 5.2 on the sisters' identification of work problems confirm the findings obtained from the Barr dependency checklists and staffing levels. No one problem was identified by all four ward sisters, although six problems were identified by three of them and another two, by two of them. Edale and Windermere ward sisters shared similar problems in relation to the workload and staffing levels.

The six problems identified by three out of four ward sisters included difficulties in obtaining patients' notes and X-rays, patients arriving before a bed was ready for them, and interruptions from the telephone. The nature of these problems reflected the need for the sisters to have assistance from ward clerks. It was reported earlier that the lack of ancillary staff employed on the wards at City hospital was identified as a cause for concern because of the subsequent dependence on students as the workforce. Other support services such as getting the ward cleaned properly and maintenance of ward equipment/furniture were also identified by three sisters as work

problems.

Another problem identified by three ward sisters related to doctors not giving sufficient explanations to patients. The way in which the sisters worked with doctors is explored further in chapter 6, section 6.3, where findings of relevance to a discussion of the sisters' ward management styles are presented.

The findings presented in the ward profiles, and the students' views on the nature of the work and the learning material, suggest that the patient populations on Edale, Ronda and Kinder wards could be characterised as generating predominantly medical/technical work with basic care required by a minority of patients.

In comparison Windermere, and later Edale, were characterised as wards where the patient populations required primarily physical care. The sister on Windermere ward was the only one of the four sisters on the study wards to prioritise the need for nurses to express an explicit commitment to the nursing process and give patients affective care. However, students perceived the use of the nursing process on Windermere as impractical because of the heavy workload.

Students' identification of the learning material changed according to their stage of training. First year students were likely to identify all nursing work as learning material including basic and affective nursing. Technical and emergency nursing was seen to be the work and learning material of more senior students and trained nurses. However, not all first year students on Windermere ward viewed the basic and physically demanding nature of the work as learning material.

Third year students were more concerned with gaining medical, technical, management and teaching experience. Edale and Ronda wards were both identified as offering good learning material for students in

their third year. The nursing process was not voluntarily identified by students at any stage of training (even on Windermere) as providing explicit learning material. This finding is consistent with findings presented in chapter 4, section 4.2.2 (p.160), that students did not perceive the nursing process as a viable alternative to medical/technical knowledge. The application of these findings to a discussion of the ward learning process is presented in chapter 8.

5.4 Ward Learning Environment Questionnaires: Student Ratings on the Nature of the Work and the Learning Material

In this section the questionnaire findings are presented, to provide additional evidence to findings obtained during interviews and participant observation. Tables 5.19 - 5.27 show overall and item scores or ratings obtained for 12 medical wards. Figures 5.1 - 5.9, which accompany the tables, demonstrate the significance of the findings at the 0.05 level when mean scores were compared between pairs of wards using Gabriel's test.

Firstly, findings obtained during interviews and participant observation suggested that the questionnaire scores relevant for describing students' views on the nature of the nursing work and learning material on different wards were: overall ratings (the mean of the sum of total item scores); Item 5: 'There is very much to learn on this ward'; Item 4: 'The number of staff is adequate for the workload'; and Item 6: 'There are enough trained nurses in relation to learners and auxiliaries'. Item scores represented the mean of the sum of scores for each item.

Secondly, ratings by ward and module are presented to explore the finding obtained from an analysis of interview data that stage of training influenced students' perceptions of the nature of the work and the learning material on different wards.

Thirdly, stress ratings are presented for each ward calculated from Item 36, which asked 'Do/did you experience anxiety or stress whilst

working on this ward?'.

Fourthly, relationships between scores on different items and sections were tested, using Pearson's correlation coefficient.

Finally, an analysis of responses to open-ended questions 38, 39 and 37 on the questionnaire are presented in section 5.4.5, as additional evidence to support findings obtained from other methods of data collection.

5.4.1 Overall ward ratings and item scores

As described in chapter 3, section 3.4.2, mean scores were derived from a rating scale of 5,4,3,2,1 for the most to least favourable student responses on the ward learning environment questionnaires.

The overall ratings or scores (i.e. the mean of the sum of total item scores) presented in table 5.19 showed a range of from 3.78 to 3.01 for the 12 medical wards under study. The wards ranked 1 to 10 scored from 3.78 to 3.41. As figure 5.1 demonstrates, with the exception of the top ranking ward the scores were not significantly different. The wards ranked eleventh and twelfth had mean scores of 3.11 and 3.01 respectively. Figure 5.1 demonstrates that these scores were significantly different from those of the ten other wards, but were not significantly different from each other.

It appears from the overall mean scores that specialty, based on the predominant diagnosis of the patient population related to medical specialty, influenced but did not play a unique role in the students' overall perception of a favourable learning environment. For example, on the wards ranked first to fourth overall, the predominant diagnosis of the patient populations related to clearly defined medical specialties, i.e. cardiology, oncology and gastroenterology. However, wards with a high percentage of 'heavy' elderly female patients (ranked eighth, ninth and tenth), which tended to overshadow their underlying

Table 5.19

Students' overall ratings of 12 medical wards as learning environments

WARD	WARD SPECIALTY & PATIENT CHARACTERISTICS	NUMBER	MEAN	S.D.
1. Kinder	Cardiology - female	48	3.78	.37
2. Eskdale	Oncology - female	35	3.64	.40
3. Wastwater	Oncology - male	34	3.64	.51
4. Ronda	Gastroenterology - m/f	43	3.57	.43
5. Edale	Endocrinology - male	51	3.52	.50
6. Buttermere	Oncology - female	35	3.51	.54
7. Ambleside	Cardiology - male	47	3.47	.58
8. Langdale	Endocrinology - 'heavy' elderly female population	29	3.46	.46
9. Coniston	Gastroenterology - 'heavy' elderly female population	38	3.44	.47
10. Windermere	Respiratory medicine - 'heavy' elderly f. pop.	52	3.41	.40
11. Loughrigg	Neurology - male/female	62	3.11	.52
12. Ullswater	Respiratory medicine - male	50	3.01	.48

Figure 5.1

Gabriel's test of significance at the 0.05 level for comparison between overall ratings for pairs of wards

WARD NUMBER	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	S	N	N	N							
6	S	N	N	N	N						
7	S	N	N	N	N	N					
8	S	N	N	N	N	N	N				
9	S	N	N	N	N	N	N	N			
10	S	N	N	N	N	N	N	N	N		
11	S	S	S	S	S	S	S	S	S	S	
12	S	S	S	S	S	S	S	S	S	S	N

S - significant at the 0.05 level. N - not significant.

specialties, obtained scores which, although lower, were not significantly different when compared with scores obtained by higher ranking wards. The scores obtained by these three 'heavy' wards were significantly higher than the two wards ranked below them, even though the ward ranked eleventh admitted patients with specialist neurological conditions.

The findings presented in table 5.19 were examined further using the scores obtained for item 5 on the questionnaire, shown in table 5.20. For consistency, all scores shown in tables 5.20 - 5.26 in sections 5.4.1 and 5.4.2 are presented in original rank order of the overall scores (table 5.19).

Item 5 was as an indicator of the learning potential available in the wards in the students' eyes. As demonstrated by table 5.20, Loughrigg, a specialist neurology ward, scored the highest rating for item 5 which was significantly higher than the scores for Ronda, Edale, Langdale and Windermere wards (figure 5.2). Edale and Langdale wards shared the same medical specialty of endocrinology and Langdale and Windermere wards both had a high percentage of elderly, female, physically dependent patients. The difference in students' ratings therefore might be explained by their perceptions of the medical specialty of endocrinology and/or elderly dependent patients as generating less valuable learning material than patients on other wards with significantly higher scores. Significantly higher scores were obtained by wards with distinct medical specialties, such as cardiology and oncology as well as neurology.

Ronda and Coniston wards also shared the same specialty of gastroenterology. However, when compared with scores obtained for Loughrigg ward, Ronda's score was significantly lower whereas Coniston's score was not significant. This finding is interesting given that Coniston ward had a high percentage of elderly dependent patients

as did Langdale and Windermere wards. When scores were compared between Ronda and Coniston wards, the differences were not significant. It appeared that an elderly dependent female population did not significantly detract from students' favourable perception of the learning material on Coniston ward. Nor was the medical specialty of gastroenterology sufficient to account for students' favourable perceptions of Coniston ward, since Ronda's score was significantly lower than Loughrigg's top ranking score.

Table 5.20

Students' ratings of 12 medical wards on Item 5: 'There is very much to learn on this ward'

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	4.50	.68
2. Eskdale	35	4.43	.50
3. Wastwater	34	4.32	.67
4. Ronda	43	4.04	.61
5. Edale	51	4.08	.71
6. Buttermere	35	4.43	.50
7. Ambleside	47	4.40	.53
8. Langdale	29	3.86	.79
9. Coniston	38	4.32	.65
10. Windermere	52	3.92	.55
11. Loughrigh	62	4.52	.59
12. Ullswater	50	4.12	.59

Figure 5.2

Gabriel's test of significance at the 0.05 level for comparison between scores obtained on item 5

	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	S	S	N								
5	S	S	N	N							
6	N	N	N	S	S						
7	N	N	N	S	S	N					
8	S	S	S	N	N	S	S				
9	N	N	N	N	N	N	N	S			
10	S	S	S	N	N	S	S	N	S		
11	N	N	N	S	S	N	N	S	N	S	
12	S	N	N	N	N	N	N	N	N	N	S

On the basis of these findings, illustrated particularly by the scores obtained on item 5 by Loughrigg and Coniston wards, it appears that medical specialty and patient characteristics, although important, were not sufficient on some wards, either alone or together, to influence students' favourable perceptions of the learning material available.

Students' perceptions of workload and staffing levels on a ward were indicated by scores obtained for item 4. Their perception of trained nurse-student ratios or staffing mix were indicated by scores obtained for item 6. The findings are presented in tables 5.21 and 5.22 respectively. The statistical significance of the scores is demonstrated in accompanying figures, 5.3 and 5.4.

Table 5.21 and figure 5.3 show that the low scores obtained for item 4 were significantly lower on Edale, Langdale, Coniston and Windermere wards, when compared with the scores obtained for the other eight medical wards. Windermere ward's score was significantly lower than any other. These findings are consistent with those presented in previous sections of this chapter and suggest that students perceive that heavy workloads are generated from acutely ill patients (Edale ward) as well as from dependent elderly female patients (Langdale, Coniston and Windermere wards).

When the scores obtained for item 6 presented in table 5.22 and figure 5.4 were examined, significant differences between scores were also apparent. The score for Windermere was significantly lower than the scores for all the other wards. Coniston's score was not significantly different from the others, which may explain why the ward was perceived more favourably on item 5 than either Langdale or Windermere. Langdale's scores for item 6, when compared with scores on the other wards, were significantly lower than only three other wards. Kinder received a lower score than six other wards for item 6, two of

which were significantly lower. Given Kinder's top overall score, this finding was surprising but might be explained by students feeling that the trained staff were not always in sufficient evidence on either the main ward or the CCU, as described in the ward case study above (section 5.3.4).

Table 5.21

Students' ratings of 12 medical wards on Item 4:
'The number of staff is adequate for the workload'

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	3.79	1.15
2. Eskdale	35	4.03	.88
3. Wastwater	34	3.88	1.02
4. Ronda	43	3.93	.97
5. Edale	51	2.98	1.29
6. Buttermere	35	3.54	.91
7. Ambleside	47	4.21	.78
8. Langdale	29	3.17	1.15
9. Coniston	38	3.16	1.22
10. Windermere	52	1.56	.77
11. Loughrigg	62	3.61	1.17
12. Ullswater	50	3.68	.99

Figure 5.3

Gabriel's test of significance at the 0.05 level for comparison
between scores obtained on item 4

	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	S	S	S	S							
6	N	N	N	N	S						
7	N	N	N	N	S	S					
8	N	S	S	S	N	N	S				
9	S	S	S	S	N	N	S	N			
10	S	S	S	S	S	S	S	S	S		
11	N	N	N	N	S	N	S	N	S	S	
12	N	N	N	N	S	N	N	N	S	S	N

Table 5.22

Students' ratings of 12 medical wards on Item 6: 'There are enough trained nurses in relation to learners and auxiliaries'

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	3.70	1.09
2. Eskdale	35	4.37	.59
3. Wastwater	34	3.50	1.04
4. Ronda	43	4.21	.73
5. Edale	51	3.66	1.04
6. Buttermere	35	3.94	.86
7. Ambleside	47	4.15	.82
8. Langdale	29	3.41	1.03
9. Coniston	38	3.79	1.03
10. Windermere	52	2.37	1.21
11. Loughrigg	62	4.05	1.02
12. Ullswater	50	3.58	.92

Figure 5.4

Gabriel's test of significance at the 0.05 level for comparison between scores obtained on item 6

	1	2	3	4	5	6	7	8	9	10	11
2	S										
3	N	S									
4	S	N	S								
5	N	S	N	S							
6	N	N	N	N	N						
7	N	N	S	N	S	N					
8	N	S	N	S	N	N	S				
9	N	N	N	N	N	N	N	N			
10	S	S	S	S	S	S	S	S	S		
11	N	N	S	N	N	N	N	S	N	S	
12	N	S	N	S	N	N	S	N	N	S	N

5.4.2 Stage of training

Table 5.23

Module 1 students' overall ratings of 12 medical wards as learning environments

WARD	NUMBER	MEAN	S.D.
1. Kinder	17	3.90	.34
2. Eskdale	7	3.86	.23
3. Wastwater	6	3.96	.33
4. Ronda	14	3.71	.28
5. Edale	15	3.86	.36
6. Buttermere	7	3.91	.25
7. Ambleside	15	3.58	.53
8. Langdale	11	3.46	.45
9. Coniston	13	3.58	.35
10. Windermere	16	3.45	.34
11. Loughrigg	8	3.68	.42
12. Ullswater	13	3.28	.34

Range of scores: 3.96 - 3.28.

Figure 5.5

Gabriel's test of significance at the 0.05 level for comparison between scores obtained from Module 1 students

	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	N	N	N	N							
6	N	N	N	N	N						
7	N	N	N	N	N	N					
8	S	N	N	N	N	N	N				
9	N	N	N	N	N	N	N	N			
10	S	N	S	N	S	N	N	N	N		
11	N	N	N	N	N	N	N	N	N	N	
12	S	S	S	S	S	S	N	N	N	N	N

Table 5.24

Module 3 students' overall ratings of 12 medical wards as learning environments

WARD	NUMBER	MEAN	S.D.
1. Kinder	11	3.85	.29
2. Eskdale	10	3.83	.38
3. Wastwater	11	3.88	.27
4. Ronda	11	3.66	.41
5. Edale	11	3.66	.47
6. Buttermere	8	3.49	.53
7. Ambleside	12	3.41	.73
8. Langdale	6	3.60	.42
9. Coniston	10	3.39	.35
10. Windermere	11	3.46	.62
11. Loughrigg	13	3.04	.51
12. Ullswater	11	2.84	.50

Range of scores: 3.88 - 2.84

Figure 5.6

Gabriel's test of significance at the 0.05 level for comparison between scores obtained from Module 3 students

	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	N	N	N	N							
6	N	N	N	N	N						
7	N	N	N	N	N	N					
8	N	N	N	N	N	N	N				
9	N	N	N	N	N	N	N	N			
10	N	N	N	N	N	N	N	N	N		
11	S	S	S	S	S	N	N	N	N	N	
12	S	S	S	S	S	S	S	S	S	S	N

Table 5.25

Module 12 students' overall ratings of 12 medical wards as learning environments

WARD	NUMBER	MEAN	S.D.
1. Kinder	8	3.62	.35
2. Eskdale	8	3.56	.36
3. Wastwater	6	3.37	.54
4. Ronda	9	3.46	.55
5. Edale	10	3.23	.55
6. Buttermere	9	3.23	.65
7. Ambleside	12	3.20	.47
8. Langdale	6	3.23	.39
9. Coniston	9	3.53	.64
10. Windermere	11	3.27	.36
11. Loughrigg	18	2.85	.49
12. Ullswater	12	3.00	.60

Range of scores: 3.62 - 2.85

Figure 5.7

Gabriel's test of significance at the 0.05 level for comparison between scores obtained from Module 12 students

	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	N	N	N	N							
6	N	N	N	N	N						
7	N	N	N	N	N	N					
8	N	N	N	N	N	N	N				
9	N	N	N	N	N	N	N	N			
10	N	N	N	N	N	N	N	N	N		
11	S	N	N	N	N	N	N	N	N	N	
12	N	N	N	N	N	N	N	N	N	N	N

Table 5.26

Module 14 students' overall ratings of 12 medical wards as learning environments

WARD	NUMBER	MEAN	S.D.
1. Kinder	12	3.63	.45
2. Eskdale	10	3.37	.39
3. Wastwater	11	3.37	.59
4. Ronda	9	3.35	.45
5. Edale	15	3.27	.37
6. Buttermere	11	3.51	.51
7. Ambleside	8	3.74	.45
8. Langdale	6	3.52	.62
9. Coniston	6	3.12	.56
10. Windermere	14	3.42	.29
11. Loughrigg	23	3.15	.44
12. Ullswater	14	2.89	.4

Range of scores: 3.74 - 2.89

Figure 5.8

Gabriel's test of significance at the 0.05 level for comparison between scores obtained from Module 14 students

	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	N	N	N	N							
6	N	N	N	N	N						
7	N	N	N	N	N	N					
8	N	N	N	N	N	N	N				
9	N	N	N	N	N	N	N	N			
10	N	N	N	N	N	N	N	N	N		
11	N	N	N	N	N	N	N	N	N	N	
12	S	S	S	S	N	S	S	S	N	S	N

Tables 5.23 - 5.26 and figures 5.5 to 5.8 show that stage of training appeared to have little influence on students' attitudes towards different wards as learning environments, although some significant differences between scores were demonstrated. Looking at the range of scores presented at the bottom of each of the tables 5.23 - 5.26, first ward students tended to rate the wards more positively as a learning environment than both third warders and third year students. However,

the upper range of the scores for first years as a group was more favourable than those awarded by third years. The least favourable range of scores was awarded by students in module 12.

It emerged from interview findings that Loughrigg ward might be considered as too specialised to provide a favourable learning environment for first warders. This finding was not confirmed by questionnaire findings presented in table 5.23 and figure 5.5. The three wards which offered students learning material generated from elderly dependent patients and were popularly believed to be ideal first ward allocations (see sections 5.2 and 5.3.2) were not confirmed by the questionnaire data in the cases of Windermere and Langdale wards. Langdale scored significantly lower than Kinder, the top ranking ward, whilst Windermere scored significantly lower than Kinder, Westwater and Edale. The lowest ward in the overall rank order, Ullswater (table 5.19), scored significantly lower in six cases, which together with scores for module 3 (table 5.24 and figure 5.6) and module 14 (table 5.26 and figure 5.8) suggests that, irrespective of stage of training, students were likely to perceive it less favourably than other wards as a learning environment. Similar inferences might also be drawn with some caution for Loughrigg ward, as demonstrated by table 5.24 and figure 5.6 for module 3, and table 5.25 and figure 5.7 for module 12 students.

5.4.3 Stress ratings

As described in chapter 3, section 3.4.2, item score 36 was used as an indicator of students' perception of stress or anxiety experienced on a ward. An anxiety or stress rating for each ward was obtained by calculating a mean score for the frequency with which students said they experienced these emotions on the ward. The highest rating was 3.0 (frequently experienced), 2.0 (occasionally experienced), 1.0 (experienced not very often), 0 (never experienced). The scores are presented in table 5.27 and their statistical significance in figure 5.9 below.

Table 5.27

Students' ratings 12 medical wards on Item 36:
frequency of experiencing anxiety or stress

WARD	NUMBER	MEAN	S.D.
1. Edale	51	2.24	.68
2. Windermere	52	2.10	.89
3. Ronda	43	1.56	.77
4. Kinder	48	1.44	.80
5. Langdale	29	1.55	.69
6. Ullswater	50	1.74	.72
7. Coniston	38	1.53	.86
8. Ambleside	47	1.62	.90
9. Loughrigg	62	1.82	.78
10. Eskdale	35	1.71	.75
11. Buttermere	35	2.23	.69
12. Wastwater	34	2.21	.69

Maximum score 3, minimum 0.

Figure 5.9

Gabriel's test of significance at the 0.05 level for comparison
between scores obtained on item 36

	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	S	S									
4	S	S	N								
5	S	S	N	N							
6	S	S	N	N	N						
7	S	S	N	N	N	N					
8	S	S	N	N	N	N	N				
9	S	S	N	N	N	N	N	N			
10	S	S	N	N	N	N	N	N	N		
11	N	N	S	S	S	S	S	S	S	S	
12	N	N	S	S	S	S	S	S	S	S	N

It appeared that students experienced anxiety or stress whilst working on wards. No ward achieved a 'zero' stress rating, i.e. anxiety or stress was 'never' not experienced by students as a group on any one ward. The scores for item 36 presented in table 5.27 ranged from 2.23 to 1.44.

Four wards were shown to have stress ratings that were significantly higher than ratings obtained for the eight other medical

wards in the study. These wards were Edale, Windermere, and two oncology wards, Buttermere and Wastwater. It could be that the nature of the work on these four wards was most stressful for the following reasons. The workload on Edale and Windermere wards was particularly demanding, as shown by the findings presented in other sections of this chapter (5.3.1, 5.3.2, 5.4.5). Two out of the three oncology wards received high stress ratings and this type of work is also highly demanding. Causes of stress other than those associated with the 'nature of the work' are examined in subsequent chapters.

5.4.4 Relationships between scores

Relationships between the following variables for the 12 medical wards were examined using Pearson's correlation coefficient. Since students' perceptions of workload and staffing levels and learning potential appeared to be associated, the relationship between item scores (4, 5, 6, 36) on the questionnaire were examined. The correlation coefficient between items 4 and 5 was 0.59 ($p = < 0.05$) and between items 5 and 6 0.60 ($p = < 0.05$). These findings indicate a considerable and significant association between students' perception of learning potential both in terms of the nature of the work, the workload, and staffing adequacy when judging ward learning environments. A significant relationship between items 4 and 36 was not demonstrated (0.35, $p = > 0.20$). The lack of a significant relationship between items 4 and 36 indicates that, overall, stress or anxiety was associated with a variety of causes, rather than a single factor such as demanding workload.

5.4.5 Analysis of responses to open-ended questions

(a) Question 38: Work and other experiences described as most valuable to education

Students' responses to question 38, based on a random sample of a minimum of ten comments per ward and four modules, yielded a total of

158 comments from 79 respondents. The comments were classified into categories indicated in chapter 3, section 3.4.2. 100 comments referred to educationally valuable work and other experiences associated with the nature of the work generated by the patient population. 71 comments described the type of patient on the ward as valuable to education according to specific characteristics, basic, technical, and affective needs (tables 5.28 - 5.31). 29 comments described diagnosis, specialist medical knowledge, investigation, and treatment generated by the patient population on the ward, as valuable to education (Table 5.32).

Table 5.28

Work and other experiences identified as valuable to education:
patient characteristics (12 medical wards, 79 questionnaire
respondents)

VALUABLE EDUCATIONAL EXPERIENCES	NO. OF COMMENTS
<u>Caring for:</u>	
Elderly mentally infirm patients	4
Women patients	1
Elderly patients	1
TOTAL:	<u>6</u>

Table 5.29

Work and other experiences identified as valuable to education:
basic nursing (12 medical wards, 79 questionnaire respondents)

VALUABLE EDUCATIONAL EXPERIENCES	NO. OF COMMENTS
Basic/general/routine	9
Heavy work	2
Night duty	1
Last offices	1
Severely ill patient	1
Unconscious patient	1
TOTAL:	<u>15</u>

Table 5.30

Work and other experiences identified as valuable to education:
technical nursing (12 medical wards, 79 questionnaire respondents)

VALUABLE EDUCATIONAL EXPERIENCES	NO. OF COMMENTS
Chemotherapy and radiotherapy	7
Barrier nursing	4
Observations (e.g. temperature, pulse, respiration, blood pressure)	3
Surgical dressings	2
Cardiac arrest/emergency	2
Drug rounds	1
Injections	1
Intravenous antibiotics	1
ECGs and cardiac monitoring	1
Underwater seal drainage	1
Tracheostomy and airway	1
Unspecified procedures	2
TOTAL:	<u>26</u>

Table 5.31

Work and other experiences identified as valuable to education:
affective nursing (3 oncology wards and 9 other medical wards,
79 questionnaire respondents)

VALUABLE EDUCATIONAL EXPERIENCES	NO. OF COMMENTS	
	ONCOLOGY WARDS	OTHER MEDICAL WARDS
Terminal care of patients including relatives	7	5
Talking to patients	3	0
Pain control	2	0
Coping with patients' and relatives' grief	1	0
Psychological care of oncology patients	1	0
Care of aggressive/violent/confused patients	0	5
TOTAL:	14	10
GRAND TOTAL:	<u>24</u>	

Table 5.32

Work and other experiences identified as valuable to education:
specialist medical knowledge, investigations and treatment
(12 medical wards, 79 questionnaire respondents)

VALUABLE EDUCATIONAL EXPERIENCES	NO. OF COMMENTS
Observation of medical investigations e.g. cardiac catheterisation, endoscopy, bronchoscopy	17
Cardiology	3
Diabetes	1
Oncological disease processes	1
Rare diseases	1
Neurological diseases	1
Anatomy and physiology of the brain	1
Acute surgical patient	1
Patient with jaundice	1
Patient with tuberculosis in isolation	1
Patient with acute respiratory disease	1
TOTAL:	29

The remaining 58 of the total 158 responses to question 38 were classified into categories which identified work and experiences valuable to education, irrespective of the ward specialty and patient population. 10 comments were made about formal teaching and 8 comments about teaching and working together. 19 comments described management experience and a further 10 referred to teaching others as valuable to education. 7 comments referred to staff relations and 4 comments to feelings about work or an experience which the student identified as valuable to her/his education. Work and experiences identified as valuable to education other than those associated with the nature of the work and the learning material are elaborated in chapter 8 as being relevant to a discussion of the students' ward learning process.

Tables 5.28 - 5.32 presented in this section show that students as a group were more likely to identify technical nursing (table 5.30: 26 comments) and experiences associated with diseases and specialist medical intervention (table 5.32: 29 comments) as valuable to their education rather than basic (table 5.29: 15 comments) and affective

nursing (table 5.31: 24 comments). 6 more comments (table 5.28) identified specific patient characteristics according to gender and age as valuable to education. A male student identified 'care of women' as valuable to his education, since he had been allocated to his first all female ward during module 12, following a change in the allocation policy at City hospital. Until 1983, men had been allocated only to male and 'mixed sex' wards. Only 5 respondents identified care of the elderly/elderly mentally infirm as valuable to their education.

These comments provide further evidence to support the hypothesis that students associated good ward learning environments with patients who provided opportunities for technical nursing and specialist medical intervention rather than wards whose patients were elderly and/or whose physical needs generated heavy, 'routine', basic work. The influence of stage of training on students' perceptions of basic nursing as a valuable educational experience was in evidence, since all the comments in this category, with the exception of one respondent, were made by first year students.

Table 5.31 presents findings which suggest that 'affective' nursing was more likely to be identified by students as valuable to their education on oncology wards, rather than on general medical wards. Even though deaths occurred and patients with cancer were admitted to all medical wards, students were better able to identify affective nursing (e.g. care of terminal patients and their relatives, talking to them and controlling their pain) for patients on oncology rather than general medical wards. These findings support findings presented in section 5.2.3(a) which suggested that the identification by students of affective work and the need to do emotional labour was legitimated by patients being on oncology rather than general medical wards. The affective needs of patients with diagnoses other than cancer also appeared to be less readily identified.

(b) Question 39: Work and other experiences identified as least valuable to education

A total of 66 comments were made by 52 questionnaire respondents about work and other experiences identified as least valuable to their education. The comments were classified using the same categories yielded from comments made in response to Question 38 with an additional category for work and other experiences described as 'non-nursing duties'.

The comments of 3 first year and 3 third year respondents implied that they considered all ward experience to be valuable to their education.

14 out of a total of 22 comments about the nature of the work identified routine basic work generated by elderly and/or physically dependent patients as least valuable to education. Respondents were just as likely to be first year as third year students. Thus, on the basis of findings presented in section 5.4.5(a), although the majority of students who identified basic routine work as valuable to education were first years, not all first years perceived such work in this way.

2 respondents commented that they viewed repeating a specialty as having little educational value to their education, a finding which also emerged during the analysis of interview data. Respondents not only commented on geriatric wards in this way, but also if they had been allocated to a medical and surgical ward of the same specialty, such as gastroenterology.

2 respondents identified oncology and 1 respondent identified neurology as 'very specialised' wards which made them 'least valuable' to education. One comment, that 'lack of work' as an experience of least educational value on a ward, suggested that without 'work' potential learning material could not be identified.

A third year respondent identified change in specialty whilst she was allocated to Windermere ward as being least valuable to her

education. As mentioned above, she commented that the staff were inadequately prepared for the changeover from geriatric to more acute medicine. On the same ward, before the changeover, a third ward student identified night duty as least valuable to her learning because of 'constantly trying to meet patients' demands'.

Replies to Question 39 also suggested that stress generated from the nature of the work on a ward might actually militate against learning (8 comments). One third year student, for example, commented that working on an oncology ward 'imposed stress on me as a person'. Two respondents on Windermere ward experienced stress, physical tiredness and depression, because of being unable to get the work done. Reasons for these feelings were twofold: the amount of work required from the type of elderly patients admitted to the ward and the lack of staff to carry out the work.

Experiences identified as least valuable to education irrespective of ward specialty (30 comments) are discussed in chapter 8.

(c) Question 37: The main causes of stress or anxiety identified whilst working on this ward

Stress ratings for 12 medical wards are presented in table 5.27 (section 5.4.3 above).

Students' responses to Question 37, which asked them to identify the main causes of stress or anxiety experienced whilst working on one of 12 medical wards, yielded a total of 106 comments from 79 questionnaires and 57 replies. 22 questionnaire respondents did not comment on causes of stress or anxiety on a ward. The comments were classified into categories indicated in chapter 3, section 3.4.2, according to causes identified.

27 comments identified staff relations (used as an indicator of ward management styles) as a cause of stress or anxiety. 28 comments were made about 'feelings' triggered by an underlying cause of stress, which

in turn were identified as a secondary cause of stress. 9 comments were classified as 'other' as they did not fit into any of the above categories nor form a discrete one of their own. The various causes of stress identified by respondents, other than those associated with the nature of the work, are discussed in chapters 6-8 below.

18 comments were made which directly associated the nature of the work as a cause of stress or anxiety. A further 24 comments identified causes of stress such as inadequate staffing levels (15 comments) and the high workload (9 comments).

Comments on causes of stress/anxiety related to heavy workload came from students on the three wards with a predominance of elderly female dependent patients, namely Windermere, Langdale and Coniston wards, and also from students on Edale ward following the change in specialty from acute to geriatric medicine.

Students on all three oncology wards identified the care of the dying patient as a cause of stress/anxiety, and so also did students on Ronda and Ambleside wards. Students' comments on the causes of stress/anxiety in the cardiology wards, Kinder and Ambleside, related to the 'risk of an emergency' such as cardiac arrest, rather than to one actually happening.

The interaction between students' perceptions of lack of trained staff and nature of the work as a cause of stress/anxiety was demonstrated by comments made by 3 respondents on Kinder ward. As mentioned, the presence of the coronary care unit (CCU) meant that on night duty and during coffee breaks third year students relieved trained staff either in the unit or on the main ward. The students experienced stress/anxiety because they felt inadequately prepared to deal with cardiac emergencies without the support of trained staff.

First ward students commented that they experienced stress or anxiety on Loughrigg ward as the nature of the work was 'too specialised for a first warder'.

Ullswater was the only ward not to receive comments on causes of stress/anxiety associated with the nature of the work.

It was also noted in section 5.4.4(b) above that responses to Question 39 suggested that stress generated from the nature of the work on a ward was identified by students as one of the experiences that was least valuable for their education.

5.5 Summary of the Findings

The findings obtained using a multimethod approach to data collection and analysis are summarised under headings related to conceptual categories and hypotheses already described.

5.5.1 The ward learning environment according to the characteristics of the patient population

Students were more likely to associate 'good' learning environments with patient populations who have a variety of diagnoses requiring technical care and specialist medical intervention, than those wards with a high percentage of elderly, dependent patients.

Age and gender constituted important patient characteristics in terms of students' perceived nursing work and learning material. For example, elderly female patients were more likely to be seen by students as synonymous with being 'geriatric' than were male patients, irrespective of their specialist medical label.

Questionnaire findings suggested that ward specialty and patient characteristics on some wards were insufficient either alone or together, to influence students' perceptions of valuable learning material.

The nature of the work on most wards was associated with the generation of stress or anxiety, especially during night duty, caring for

physically dependent patients, oncology patients and emergencies.

The way in which the students perceived the nature of the work was also related to other variables such as workload, staffing levels and mix. Where staffing levels and/or mix were adequate for the workload, students experienced fewer feelings of stress/anxiety and were more able to view a heavy workload as learning material. In general, the staffing levels on the wards were low during the evening and night shifts.

The Barr dependency checklist (1967) was not sufficiently sensitive to monitor the workload associated with patients' psychosocial needs and physical dependency. The ward profiles confirmed findings by other researchers that the ward environment is not a 'static concept' and is constantly in a state of flux (Pembrey 1980, Fretwell 1982).

5.5.2 The status of the nursing process and the affective elements of nursing

The nursing process was not seen by students as a relevant framework for organising nursing knowledge or work methods on busy, acute wards and/or where staffing levels were low. It was perceived as more applicable to caring for dependent, elderly patients who required assistance with activities of daily living, rather than acute, technical care.

Communication with patients was identified as important learning material on oncology wards, associated with dying, pain control, and talking with patients and relatives. With the exception of care of the dying on two wards in addition to the oncology wards, such activities were not identified as learning material on the majority of medical wards.

5.5.3 Stage of training and the unique learning trajectory

Patterns of ward allocation were organised around medical specialties which did not necessarily offer an accurate view of learning material available to students of nursing (Roper 1975).

Wards at certain stages of training were perceived by students as offering more appropriate learning material than at others. However, these perceptions were shaped by students' previous learning trajectories and patterns of ward allocation. Stage of training was also important in determining what a student was expected to do, irrespective of the content of previous ward experiences. Third year students, for example, identified key procedures (such as managing a cardiac arrest, last offices and passing a naso-gastric tube) which they hoped to be able to perform by the end of their training. They also valued being able to gain management and teaching experience.

In general, the specialist medical wards (neurology, cardiology and oncology) were regarded by students as offering 'good' learning material, in their third year of training.

First year students, especially on their first ward, identified the majority of nursing activities as learning, including assisting patients with their physical and affective needs and talking to them. The belief that 'basic nursing care' generated from elderly dependent patients provided 'ideal' learning material for first year students was not confirmed by questionnaire findings. Although the majority of students who identified 'basic, routine work' as valuable learning material were in their first year of training, not all first year students perceived such work in this way. The belief that oncology and neurology wards were 'too specialised' for first ward students was not confirmed by the questionnaire findings.

5.5.4 The student as worker

Student learning trajectories and patterns of ward allocation described by the City hospital allocation officer and students were planned to fulfil service rather than learning needs, on general medical and surgical wards.

Students saw their ward activities primarily as work which they might also identify as learning material, depending on stage of training and predominant specialty of the ward to which they were allocated.

4

CHAPTER 6

SISTERS AND WARD MANAGEMENT STYLES

Introduction

This chapter describes sisters' ward management styles, in order to discuss their implications for quality of nursing in chapter 7, and student nurse learning in chapter 8. Ward management styles are described in terms of ward atmospheres and the social relations of trained staff to students and patients. The sister's interpretation of the nursing process is used as an indicator of ward management style. The way in which the ward sister interpreted the nursing process for handling information and feedback amongst nurses and prioritising technical, basic and affective care is described. The sister's recognition of the affective elements of nursing, which required nurses to do emotional labour, is assessed. The findings are derived from: (a) interviews with students, ward sisters and tutors; (b) field observations from four study wards; and (c) self-administered questionnaires on students' attitudes towards the ward learning environment.

The chapter contains four parts. The first part presents interview data from students and nurse teachers, in order to explore features of ward management styles that are considered as favourable or less favourable to quality of nursing and the ward learning environment. In the second part, case studies are presented to illustrate different management styles in operation on four medical wards. The case studies are constructed from data collected through field observations, interviews and questionnaire comments.

The third part examines questionnaire findings on the ward learning environment relevant to sisters and ward management styles (score for section B) and its relationship with two other variables: item score 2

(I am happy with the experience I had on this ward), and item score 36 (ward stress ratings). Students' responses to open-ended question 37, on causes of stress or anxiety associated with sisters and ward management styles, are examined. Responses to question 41 in which students gave an overview of their ward experiences, including sisters' ward management styles, are included.

A final part summarises the findings obtained using the different research techniques.

6.1 Interview Findings

In this section, the findings from data obtained during interviews are used to describe ward management styles with reference to the working hypotheses formulated in the early stages of the research by specifying in which way management styles shaped the quality of nursing and ward learning. During the interviews, it emerged that students viewed accessibility and approachability of staff as positive features of ward management styles; that sisters' ward management styles were associated with how they interpreted the nursing process; and sisters who were accessible and approachable were more likely to use the nursing process as a way of making the affective elements of nursing more visible and recognise the need to do emotional labour.

6.1.1 Ward management styles

During interviews, it emerged that certain styles of management were looked upon more favourably by students, both in relation to their own learning and the quality of nursing that they felt able to give, as the following statements imply:

Sister on this specialist surgical ward was very good. She sat me down on my first shift and said 'This is what I expect from a third year' ... and then she ran through some of the major operations so I knew where I stood from the beginning. I said to her 'If every sister did that, the wards would run so much smoother'.

Another third year expressed a similar view about the sister on Ambleside ward:

I think the whole ward was run very smoothly because you knew where you were. She had rules. She let you know what the rules were.

Yet another third year student made similar observations about a ward where he felt he had had the support not only to ask for help if he 'came across a problem' but also to be 'more single-minded' in the care he was giving. He concluded:

You are doing what you are doing because that's how you want to do it and you are not worrying about someone coming round your neck and saying 'Don't do this, do this'.

It may be inferred from these comments that when students knew what rules or expectations a sister had for them during a ward allocation, the ward ran smoothly, and favourably influenced the quality of nursing that patients received. On the one hand, the giving of information helped students to learn about how they should care for patients. On the other, the giving of information and support by trained staff enhanced the quality of nursing students were able to give.

During interview, it also became apparent that students associated a supportive management style with a relaxed ward atmosphere. The implications of a supportive, relaxed atmosphere for quality of nursing is illustrated in the following statements made about Wastwater oncology ward, by third and first year students respectively. The third year student said:

It was a ward where it was very easy to feel at ease, which I think is actually very good for nursing care, if you feel relaxed with people.

The first year student confirmed that:

The standard was very high. I mean we had a very ... well, not casual, but a very easy going relationship. Everybody was called by their first names and you had a real laugh. But I don't think the standard of nursing dropped at all because we had a lot of terminal patients and they were always top priority.

The importance of the sister and trained staff as a group, to the students, is illustrated by the following quotations:

It's incredible the difference the staff make to a ward. It's like another ward when they change. (Third year student)

Another third year student said how important it was to see the sister out on the ward rather than 'just sitting in the office, sending the orders down'. Both she and another third year student felt that it was important the trained staff saw 'what's going on'. By being on the ward rather than the office the staff were accessible so that 'You feel you can go and talk to them. They are approachable'. By contrast another student thought that :

Any socialising that goes on is separate and is between students ... The trained staff never really get to know students as people ... on the last ward you weren't allowed in the office if anybody trained was there. We'd have to go in the day room with the patients.

The separation between trained staff and students associated with their perceived inaccessibility in 'sister's office' was frequently mentioned by students during interview. One student in her final module thought that the trained staff had 'improved since I started training, but there is still this tendency to sit in the office drinking coffee'.

Another student was of the opinion that :

It's easy (for the trained staff) to get out of touch with patient care. Staff nurses need to take it in turns caring for patients. It's important for them to see the amount of work students do.

The implications for quality of nursing of trained staff working alongside students and taking an interest in them is summed up by a student in her final module:

I think students work jolly hard if they are working with somebody who understands them a bit more and thanks them at the end of the shift, rather than somebody who is bossing them around all the time. I know a lot of people feel like that.

Repeatedly, it was the ward sister who was identified as the key person on the ward in terms of the social relations and the atmosphere that she created. The following statements illustrate this view:

Sisters are critical because of their influence on staff nurses. They in turn influence how the students work and on the way they feel, their morale. (Third year student)

Sister's attitude is very important ... On sister depends the happiness of staff nurses and students. (Third year student)

The ways in which the sister's style of management shaped the social relations between nurses and the ward atmosphere, as described by students, is illustrated below:

The communication between trained staff and learners on Wastwater was very very good. Especially sister and the staff nurses were very approachable. I mean, you could have a real laugh with them and sister you could really giggle with. And yet you still had that distance where you respected her. (First year student)

A third year student had similar views about a surgical ward sister whose management style she had particularly respected:

She's very good (technically competent), very nice, very funny. She makes the ward happy.

This same student thought that, in general, staff nurses tried to 'create a good impression with sister who is the organising figure'.

The implications of different styles of management for student learning and socialisation are discussed more fully in chapter 8. The implications of different management styles for patient care are elaborated further here. It was noted in chapter 3 that the negotiation of the research role highlighted the hierarchical nature of the relations within nursing. Similarly, the inferences that can be drawn from one student's view elaborated below, and supported by interview data already presented, is that the sister's personal management style was superimposed upon those hierarchical relationships:

Sister is undoubtedly critical. Sister is undoubtedly the key. I believe in the fact that it all goes up in the system and I feel the sister of the ward, she sets the pace ... She always informs the staff nurses and they will do things according to her wishes. I have been on wards where they totally disagree with things she has given them to do. But they are still done.

The same student then went on to discuss the importance of 'caring' as a feature of ward management styles:

You have to respect someone in your team because of the kind of work you do. So if you can look up to her (sister) and respect her and if I know she cares, then I feel a bit more at ease and I don't feel that I have to take the whole caring attitude of the whole ward on my shoulders.

The student identified the following to be indicators of a 'caring'

management style: 'seeing sister happy; being told what she (the student) wanted to know; seeing sister going round talking to patients and relatives'.

Similar indicators of 'caring' management styles were given by other students. For example, a first year student said about Sister Buttermere:

Sister is genuinely concerned about the patients. Some sisters aren't. They are more into sitting in their little room and having coffee. Sister will stay until six o'clock if someone is upset, you know.*

Sister Buttermere's caring style created an atmosphere on the ward, according to the student, which nurses 'picked up' so that:

... everything people wanted was done. I mean it wasn't done grudgingly, it was done well ... I would really want to do things for people.

Two third year students expressed the view that patients like nurses were sensitive to ward atmospheres created by the sister. Patients knew, for example, if the students were not happy or morale was low. In one student's experience, this had resulted in the patients not wanting 'to bother the "poor nurses"'.

The students' accounts of ward management styles reported during interviews appeared to support the findings of McGhee (1961) and Orton (1981), that the importance of the ward sister could not be overemphasised in relation to patients and students, who judged her by the atmosphere of her ward.

The indicators of 'caring' styles of management might be interpreted as the sister's recognition of the importance of the affective elements of nursing, to the care of both patients and students. In order to care for the affective needs of patients and students, sisters were seen to undertake emotional labour to create a 'caring' atmosphere. Taking the

* Early shift finishes at 4.15 pm.

notion of emotional labour further, as conceptualised by Hochschild (1983), it could be inferred that students, by describing sisters as 'caring', were identifying the emotional style in which they nursed patients as well as managed their wards. Referring back to the review of Hochschild's work in chapter 2, section 2.1.1, p.30), it will be recalled that airline passengers were said to judge the quality of the service by the emotional style in which it was given, which in turn was described as 'part of the service itself'.

Students recognised that those sisters who managed feelings to make the ward happy were those who responded to them as people as well as nurses. They were also more likely to be in direct contact with patients, undertaking emotional labour. Students reported that they were more able to do emotional labour for patients if they felt that ward sisters both cared about them (the students) and the patients, as indicated by the emotional style in which they managed their wards. Parker's (1980) distinction between the two fundamental features of care work, described as caring about and caring for, seem to be of relevance here, since the students appeared to be describing ward sisters whose emotional style of management indicated that they were people orientated (caring about) rather than task orientated (caring for).

Findings presented in chapter 5, sections 5.2.3(a) and 5.4.5(a) suggested that the specialty of oncology and the affective elements of nursing were more frequently associated by students working on oncology wards than on general medical wards. Analysis of interview data confirms these findings, in that the oncology ward sisters were frequently mentioned by students as demonstrating a 'caring' management style. It is interesting to speculate as to whether the need to do emotional labour was more closely associated with patients suffering from cancer, and so students were more aware that it was being done on

those wards; or that sisters who were interested in prioritising the affective elements of nursing chose to specialise in oncological nursing.

In summary, interview findings presented so far appear to confirm that management styles shaped quality of nursing and ward learning through the creation of the ward atmosphere and the way in which the sister articulated the social relations between herself, trained staff, learners and patients. Accessibility and approachability as features of those styles were viewed favourably by students, in terms of quality of nursing and the learning environment. A 'caring' style was also associated with accessibility and approachability of trained staff to students and patients. Trained staff as well as students were in direct patient contact and the affective elements of nursing and emotional labour were made visible by sisters. Students also suggested that patients recognised the importance of affective nursing and emotional labour to the creation of a positive ward atmosphere. Patients' views are elaborated further in chapter 7, section 7.1.

6.1.2 The nursing process as an indicator of management styles

As described in chapter 4, section 4.2.2 (p.160), students did not automatically place the nursing process within the theoretical context of their training. As confirmed in chapter 5, neither did students identify the use of the nursing process on the ward as learning material. Overall, however, they appeared to recognise the underlying philosophy of the nursing process, as a person orientated rather than task orientated approach to patient care and as a means of improving verbal and written communication between nurses through detailed kardex records and handover reports.

Third year students were better able to describe the nursing process in these terms than first years. Third year students also recognised the notion of long term patient-nurse allocation, although they

reported that it was rarely practised in the ward, nurses usually being allocated new patients daily. The issue of patient allocation is discussed more fully in the ward case studies below (section 6.2).

As mentioned in chapter 5, section 5.2.3(a), one student thought that one reason that the nursing process did not work as it was designed to was 'because of how the staff want to work' in most wards. Like many students, she identified two sisters in the hospital who managed their wards in a way that demonstrated commitment to the nursing process. These sisters were Sister Windermere and Sister Tarn Hows (geriatric rehabilitation ward). The student saw the nursing process as:

... being encouraged to use your initiative ... The whole philosophy of the ward has to be where you are given time to carry it out.

She then went on to describe how the nursing process operated on Tarn Hows. Nurses were assigned to individual patients for whom individual handover reports were given. Patient care goals were established and the care plans updated daily. The student continued 'You were encouraged to sit on the side of someone's bed whilst they got their arm into a blouse, even if it took half an hour'. Windermere was the only other ward identified by students where the sister promoted the nursing process philosophy of spending time on planning and updating patients' care through verbal and written exchange. A third year student confirmed that:

Sister Windermere doesn't mind how long it takes, but other sisters want you to get on with their routines.

Two students, a third and a first year, described how, although patient allocation was practised on wards, nurses still carried out patient care as a series of tasks rather than care centred around patients' individual needs.

A third year student giving an overview of the practise of the nursing process on a number of wards where she had worked said:

You rarely do everything for your allocated patients on a shift ... There will be other people coming in. Like if you're busy with another patient, somebody else will go and give him a mouthwash or a walk.

The practice of the nursing process on the oncology wards was frequently mentioned. This was an interesting finding given that students more readily associated the affective elements of nursing and the need to do emotional labour with patients on oncology wards. It may have been that students were equating the use of the nursing process and its underlying philosophy with wards where the sisters were described as practising a person orientated approach to care which gave recognition to patients' affective needs. However, as described below, nurses still appeared to think in terms of tasks to be performed for patients on one of the oncology wards, even though the emotional style in which the tasks were given was 'friendly'. A first year student after an allocation to Wastwater ward said:

Pressure area care and pain control are given on time. Patients had mouthwashes after every meal. Everybody was friendly and they (patients) didn't feel intimidated by a nurse stepping out on the ward. Except for Sister, we were all on first name terms.

The student continued:

Task orientation is non-existent on oncology wards; everybody is individual, nobody even thinks about the nursing process. It's just done as a matter of course ... You write up on your patients and Sister reports if something has changed.

However, the student then went on to describe how patient allocation was interpreted on the ward:

Even if you are given six patients to look after, you virtually go round the whole ward and someone else may do your four hourlies for you if you forget or if you are talking to one of their patients. You usually look after another set of patients the next day so they don't feel they are being left out.

The handling of information and feedback related to patient care varied considerably among wards. As noted at the beginning of this section, students recognised the nursing process as a means of improving verbal and written communication between nurses. Many sisters, however, continued to restrict the information and feedback given to

students about patients. One student commented:

I feel that sometimes staff withhold information that is important for patients. Like on some wards the trained staff report between themselves and the students to each other.

Another student observed during interview that:

Surely the idea of the nursing process is that everybody knows everything there is to be known (about patients) ... and you can't get that when you have two or three interpretations of each bit of information.

A first year student also drew attention to differences in interpreting information on the written kardex:

People's interpretation of what you write down is different. You could say: 'He seems rather cheerful today' and cheerful in brackets could mean a rather sort of uptight cheerful.

It appears from these comments that the way in which information and feedback on patient care is handled on different wards is one more indicator of management style in which the ward staff are accessible and approachable to students. As is further illustrated through the case studies (section 6.2 below), sisters used the ward reporting system as a way of organising and prioritising technical, basic and affective care and recognising the need to do emotional labour.

However, the limitations of the nursing process as interpreted in the general ward setting is illustrated by one third year student's description of the management styles in operation on the ward to which she was allocated during her psychiatric module. In the psychiatric ward, where communication and encounter were clearly the central work relationship, the nursing process was interpreted in a way rarely described in the general ward. The student assessed her psychiatric experience on an 'obsessions' ward in the following way:

Wonderful time, I had. For the first time ever allowed to say 'no' when I refused to treat patients in such a way ... It was a very good experience, and one key issue was that every patient is told totally what is wrong with them ... The patient had various responsibilities and that made such a difference.

She also described how staff were helped to manage difficult patient

interactions (e.g. if a patient was aggressive):

If there was an intense staff interaction and someone was very upset about a situation, it was put directly to someone in charge. Everything would stop. There would be a discussion and it wouldn't just be 'what should we do about this?'. First of all they would start on you. 'How does this upset you? Are you sure you feel alright? ... This plan of action obviously isn't working with this patient. Let's go and talk to them and let them know'.

When asked if this system of working could be applied to general nursing the student mentioned both Sister Windermere and Sister Tarn Hows as being 'open to change'. However she went on to state that 'this kind of system demands changes in attitude from every member of staff, changes in approach.' She inferred that the successful implementation of the nursing process demanded these changes, otherwise:

You are expected to support a patient in depression and you are not supported yourself. You are expected to treat the patient psychologically and you don't know how to do that. These sisters (Windermere and Tarn Hows) are very open to change with regard to the nursing process and they try desperately hard each shift to do what is right.

It was reported in chapter 4, section 4.3.2 (p.178), that the psychiatric module was identified by students and a tutor as having an important role in developing students' communication skills and psychological understanding of patients. The above description suggests that the management styles and use of the nursing process in the psychiatric setting put patients' affective needs and the need to do emotional labour at the centre of patient care.

The analysis of interview data presented so far appears to support De la Cuesta's (1983) findings that ward sisters interpreted the nursing process according to their own work preference and reality. The data also appear to support the working hypotheses that :

1. Students associate the successful implementation of the nursing process with sisters whose personal management styles are characterised by their willingness and ability to negotiate their social relations with students and others in a non-hierarchical way and demonstrate a 'caring' attitude towards nurses and patients.

2. The implementation of the nursing process demands a greater recognition of communication and encounter as the central work relationship and the need to support nurses in doing emotional labour.

6.2 Management Styles and the Nursing Process on Four Wards

The data obtained during participant observation on four wards are used as evidence to support the working hypotheses stated above in section 6.1, that: management styles shape quality of nursing and ward learning; students view accessibility and approachability of staff as positive features of ward management styles; sisters' ward management styles are associated with how they interpret the nursing process; and sisters who are accessible and approachable are more likely to use the nursing process as a way of making the affective elements of nursing more visible, and recognising the need to do emotional labour.

Participant observation was complemented by additional evidence collected during interviews and discussion. As described in chapter 3, section 3.2.3 (p.89), quantitative research techniques were also used and included Pembrey's checklist of daily work priorities completed by sisters during interview (Pembrey 1980) and Fretwell's questionnaire on the ward learning environment completed by students (Fretwell 1985). The checklist was used as an indicator of sisters' ward management styles and use of the nursing process. The findings are presented in table 6.1 below.

The questionnaire was used as a means of conceptualising the ward as a learning environment, on a number of items and dimensions, including students' perceptions of the ward atmosphere/staff relations (score B).

The questionnaire findings for 12 medical wards including the four study wards are presented in section 6.3 below. In this section, the students' responses to open-ended questions which were relevant to a discussion of management styles on the four wards are included.

Table 6.1

Prioritisation of daily work derived from Pembrey's checklist (1980)
(top priority: 2 ticks)

WORK PRIORITIES	NO. OF TICKS BY WARD SISTER ON			
	EDALE	WINDERMERE	RONDA	KINDER
Supervise patients' meals	1	2	1	0
Accompany consultant on round	1	1	1	0
Work with student	1	1	2	1
Give some nursing care	0	1	2	1
Write up kardex	0	1	2	1
Allocate work at beginning of shift	2	0	2	1
Ask nurses to report on work	2	2	1	2
Do a nursing round of patients	0	0	2	2
Give nurses a report on patients	2	0	2	2
Order stores /equipment	0	0	1	0

The findings presented in table 6.1 are of relevance to the four wards and are referred to in section (c) of each case study.

6.2.1 Management style on Edale ward

(a) Sister and staff nurses' ward management style

The findings presented below are based on field observations and an interview with the sister, during which she completed Pembrey's checklist of work priorities.

Sister Edale had a clear sense of herself as a manager of staff and patients and saw the need to train staff nurses for their role. When the researcher was on the ward, the staff nurses and the sister formed a cohesive group. They had worked together for about nine months, the majority of them having worked on the ward as senior students. Even though the sister had a reputation amongst students of being 'strict' and 'a bit of a dragon', there were usually plenty of applicants for staff nurse posts on Edale ward. The sister also asked senior students

whom she thought would be suitable to apply when posts became vacant. The sister demanded commitment from the staff nurses. She said that she trained them for their role by giving insights into their performance in order to build up their confidence. She tried to show them, she added, that they could only do their best and no more.

The trained staff usually took coffee and tea breaks in the office after the students had taken theirs. As noted in chapter 3, it was during these breaks that the researcher gained many insights into the sister's management style and views on nursing. All the trained staff usually had lunch together in the office. The lunch break gave the trained staff the opportunity to discuss what was going on in the ward as well as serving a social function. Although the trained staff formed a cohesive social group, apart from these breaks they were usually out on the ward, organising and working alongside students.

The staff nurses told the researcher that they felt that Sister Edale taught them about ward management and acute patient care, although her perceived high standards could be quite daunting for some of them, as the following quotations suggest.

Two staff nurses from other wards described their friends to the researcher in the following way. Their friends were both staff nurses on Edale during the period when the researcher was on the ward. One staff nurse said of her friend:

R has lost so much weight since she's been on Edale. She's got a permanent tachycardia.

Another staff nurse said:

Sister Edale has got such a reputation for high standards. G (friend) couldn't take it any more. Sister could pick up something, G said, and you would think 'Why didn't I think of that?'.

As described in chapter 5, section 5.3.1, the nature of the work was acute whilst the researcher was on Edale ward. For example, a number of emergency situations arose during which patients required resuscitation following respiratory arrests. Sister Edale responded quickly and

competently to the emergencies. She enjoyed the stimulation of acute medicine and remarked to the researcher after she had been involved in one particular incident that she no longer experienced an increase in her pulse rate whilst dealing with emergencies. 'I must be getting old!' she joked. During interview, she reacted to Pembrey's (1980) checklist of work problems (discussed in chapter 5) by saying:

I can't imagine what it would be like working without problems. I imagine it would be very unstimulating. I can't stand the ward when it's quiet!

One staff nurse told the researcher that she thought the students were 'very much in awe of sister. She's more like a doctor than a nurse'.

From these quotations it may be inferred that Sister Edale was perceived as highly efficient and technically competent, especially in dealing with emergency situations (equated with being 'more like a doctor') and setting high standards for those who worked with her. The nature of the work on Edale ward demanded a management style that included close supervision of students caring for acutely ill patients, and on many occasions the sister was observed to give the care herself. The staff nurses took on the work culture created by the sister. Although many of them had worked with her as students, they told the researcher that they felt very anxious when they first took up their appointments as qualified nurses. Not only were they adapting to their new role but also a demanding management style and workload. The consequences of their anxiety for students is described by a third year student below (section 6.2.1(b)).

Sister Edale told the researcher that she tried to select staff nurses who would complement her personality and style. She had been told by a former nursing officer that she was 'aggressive'. She thought that one of the reasons for this was that she would not try to cope on the ward with inadequate staffing levels. She would ask nurse managers

to arrange for extra staff when necessary. The sister did say, however, that she realised the need to appoint staff nurses who were 'not shy and able to stand up for themselves'. She gave the example of G, who was selected because she was 'motherly' and therefore more accessible to first year students than herself. Sister Edale concluded that she now concentrated on helping the staff nurses to create the learning environment rather than creating it herself.

The way in which trained staff worked with doctors was also noted as an indicator of the sister's management style. In common with two other sisters under study, Sister Edale identified 'doctors not giving patients enough explanation' as a work problem on Pembrey's checklist (chapter 5, table 5.2). Trained staff on Edale ward accompanied doctors on their ward rounds and attended the multidisciplinary team meetings organised by three of the consultants. These meetings included doctors, nurses and social workers and were arranged in order to discuss patients' social care.

There was some socialising between doctors and trained staff during tea and coffee breaks. One of the house officers often joined the staff for lunch and one of the consultants sometimes took tea with them after his ward round. Trained staff were quite clear that they did not like to 'service' doctors. They would refuse to answer house officers' bleeps for them, as was sometimes expected, or to look for items of equipment that the doctor was well able to look for him/herself. When one house officer could not find adhesive tape to secure a dressing the staff nurse asked one of the other house officers to show him where it was to be found rather than get it herself.

The staff nurses probably took their cue from the sister, who was very clear that she was not a doctor's 'handmaiden'. She also negotiated with consultants on patients' behalf. For example, a young patient who was dying was visited by his consultant, who wanted to

carry on with active investigations and treatment. The patient was unwilling to undergo the tests, knowing that he was dying. The consultant tried to persuade him to the contrary. At this juncture, the sister negotiated successfully with the consultant on the patient's behalf so that he agreed to withhold the investigations.

(b) Students' views on ward management style

Questionnaire comments on causes of stress or anxiety (Question 37) on Edale ward, suggested that the sister's management style created stress for some students. A first warder wrote: 'Sister can sometimes make students feel ill at ease'. For a student at the end of her training, stress was created by her relationship with the sister 'who undermined my confidence and made it difficult for me to show any initiative'. The negative features of Sister Edale's management style and their association with stress are summed up in one response to Question 41 on the questionnaire which sought 'other comments about the ward':

Staff nurses are excellent but anxiety would be much reduced if Sister were more approachable and easier to work with. (Third year student at end of Module 12 allocation)

The interview and field data offer further insights. Although the responses to Question 41 were made by a third year, students irrespective of stage of training were in awe of the sister. She was seen as 'strict' by all, but first year students appeared more willing than third year students to accept this feature of her style as a positive attribute. For example, a first warder said that she had 'loved' the ward. When asked why by the researcher, she said: 'Sister is wonderful; she has such high standards'. She also described the sister as 'doing things properly'. The attention to carrying out the hospital policy for the administration of drugs was frequently quoted by students as an example of Sister Edale 'doing things properly'.

The first warder added that she had been 'warned off the ward' by

other students because of the sister's reputation for high standards and because 'some people don't like being corrected'. It became apparent during the research that third year students were not used to being supervised on other wards and resented such styles of management whilst working on Edale ward.

The complex way in which the management style in operation on Edale ward shaped the quality of nursing and student learning is expressed in the following statement by a third year student:

The standards are high and I learnt a lot in that ward, but just because of those two things it didn't mean that you were well supported or the work was enjoyable ... the attitude of the people who run the ward was that they have to check on you every inch of the way and ... they were on your back badgering you and hassling you all the time .

The student went on to talk about the 'high levels of stress' which she had experienced on Edale ward. When asked to explain the causes of stress, she thought that the sister 'who sets the tone' generated anxiety in the staff nurses 'because they were responsible to sister'. As described in section 6.2.1(a) above, staff nurses told the researcher that they felt 'very anxious' when they first took up their appointments as qualified nurses on Edale ward. A number of staff nurses were in this position during the third year student's allocation. The high levels of stress had reduced morale amongst the students, according to this third year student. She thought, however, that the first warders were not so affected by the stress 'as they don't really know what to expect', whereas the third years 'have a lot more responsibility and there were people coming up to finals'.

A third year student who had just taken her state final examination felt that she was not given enough responsibility on Edale ward. When asked what she meant by 'having responsibility' she replied: 'I think it's about letting you decide for yourself about your patient or about whatever's going on in the ward'.

Another finalist who had also been a first year student on Edale ward compared her perspectives on the sister's management style at different stages of training:

When I was a first year on Edale, I had never been on a ward like this before. I was thrilled. It was a busy ward and at that level (third ward) you were busy coping and getting recognition from Sister.

Now as a senior student she did not see the management style as one of 'badgering' and not 'having enough responsibility' as the other third years had done, but as a means of ensuring 'continuity of care and expectations, which are very high between one member of trained staff and another'. It may be of significance that this student, unlike her colleagues, was a 'mature' entrant to nursing. She was perhaps more able than younger students to appreciate Sister Edale's style of management without feeling intimidated by it and to see the need for supervision in patient care.

In summary, some students experienced Sister Edale's management style as stressful. The interaction between stress, stage of training and individual students in relation to the ward learning environment, including ward management styles, is discussed further in chapter 8.

(c) The interpretation of the nursing process on Edale ward

Sister Edale was committed to the general aims of the nursing process. She practised patient allocation and expected students to give verbal and written reports on their own patients. She was much more directional in discussing and recalling information about patient care than sisters on the other study wards.

On Pembrey's checklist of daily work priorities, the sister considered that the most important jobs for her to do were to allocate the work at the beginning of the shift, ask the nurses to report on their work, and give the nurses a report on the patients (table 6.1).

The sister did not tick giving nursing care to patients as a priority on Pembrey's checklist of daily work priorities. However, she

added that she would supervise the acute care of patients as well as often giving acute emergency care herself. The need to do so frequently arose on Edale ward.

The sister did not do a daily nursing round of patients. Rather she delegated her authority to the staff nurses through the system of work allocation and reporting that she had developed. She would talk to patients as the need arose and she would maintain contact with them by aiming to do at least one drug round a day. In this way she could meet each patient and check their charts. She always spoke to the physiotherapist and pharmacist when they made their daily visits to the ward.

The nursing work on Edale ward was organised during a twenty-four hour period as follows. All nurses would take the night nurses' report. The nurse in charge would then allocate the work. Often students were given a choice as to which group of patients they would prefer to look after. One first ward student said she had managed to look after the same patient for eight consecutive days. She said it depended on the patients as to whether she minded looking after them for long periods of time or not.

The first ward students were usually allocated to work with a senior nurse during their early weeks on the ward. Depending on who was on duty, this would be either a third year student, a staff nurse or, occasionally, the sister. The staff nurses employed a style of supervision similar to that described by the sister and observed by the researcher. They would plan with the student the care to be given to the patient, observe them beginning to work, 'structure them if you can, and pick up the pieces at the end'. The trained staff's work organisation on Edale ward had some similarities with Pembrey's (1980) notion of the management cycle. They allocated the work to students, helped them to plan care for their allocated patients, recalled

information and gave them feedback at the end of the shift.

The sister was aware of the feeling amongst third year students on Edale ward that they were not given sufficient responsibility. 'That is because we allocate them patients but don't leave them in charge,' she concluded.

The work was divided by bed number as on other wards but, apart from the balcony beds which were usually occupied by low dependency patients, all beds in the main ward were equally visible from the nurses' station and could accommodate dependent patients. However, only certain beds had piped oxygen and suction overhead, being used for patients who required these facilities. Unlike on the other study wards, the work was divided into much smaller units, from between one and four patients per nurse or pair of nurses. The number of patients in the group was decided according to their dependency and the amount of physical and technical care they required.

It was customary, as on the other study wards, to make some of the unoccupied beds at the beginning of the morning shift. However, it was not seen as a task to complete, as the researcher discovered one morning whilst making beds with a first ward student. After several had been made, a third year came up and tactfully suggested that the beds could be left in order to get on with caring for patients.

The drug round was usually undertaken by the nurse in charge, with a student. Occasionally the patients' allocated nurse was called to dispense their drugs. The nurse in charge then continued to do much of the overall administration of the ward, which involved a great deal of time on the telephone. She might allocate herself one or two patients to care for, but it was more likely that she would supplement the students' care by doing complicated dressings with them and the intravenous injections that only trained staff could do. She also accompanied doctors on their rounds. Much of the telephone work

included making outpatient appointments, contacting district nurses and overseeing patients going for X-rays and other investigations.

When the afternoon staff came on duty there was a quick verbal handover from the allocated nurses, so that the nurses on the second shift would know what was going on whilst their colleagues were at lunch. All the observations were done during this time so that the patients could have a rest between two and three o'clock. The nurses were also able to have a long report session off the ward during this time.

When the morning staff returned from lunch, they took over from the afternoon staff on the ward. They would go into the reporting session to discuss their own patients only and the care they had given. The sister used the report as a teaching forum, although she was aware that not all the students saw this as teaching. The trained staff added background information about the patients, from doctors' rounds, social workers and other sources. Kardexes were written at the end of the morning or after the report by the allocated nurses. All the trained staff would have tea together at the end of the afternoon, leaving the evening shift students on the ward to do the observations.

Although they had allocated patients, the extent to which they were able to concentrate on care rather than getting tasks done depended on the numbers on duty. Before and after meals, drug rounds were performed. The trained member of staff would do all the intravenous drugs and oversee the administration of insulin, since many of the patients were diabetics. Kardexes were updated as required and the trained member of staff handed over to the night nurses. As on the other study wards, patient allocation was not able to be practised on night duty as there were usually only two nurses for the whole shift.

Sister Edale said that the ward organisation as seen by the researcher 'didn't just happen'. It had emerged over time as a result

of discussion and modification with generations of staff nurses.

The difficulties of maintaining patient allocation on an evening shift are illustrated by the following vignette. One evening, whilst the drug round was in progress, the supper arrived and a patient was incontinent. There were three third year students and the sister on duty. Two of them were doing the drug round while the others changed the incontinent high dependency patient. Soon afterwards, the accident and emergency department rang to ask the ward to accept an admission. In the midst of all this, the staff had to take their own supper breaks.

The sister used a form of patient allocation to help to overcome the conflicting demands on the students. She identified key patients within each of their allocated groups in order to help them to prioritise and focus their work. This was possible given that they were senior students. Each was given a key patient. The diversity of the patients and their needs was enormous. They included a dying man, a patient with multiple bed sores and a young drug addict who had a recent history of epileptic fits and respiratory arrests.

Field observations on the interpretation of the nursing process on Edale ward yielded interesting perspectives on patient allocation and continuity of contact, not only between patient and nurse but also between nurse and nurse. As shown by Reid (1983), the contact time between different grades of staff in giving patient care was an important indicator of student supervision. The way in which nursing was organised on Edale ward did not vary significantly from the other study wards, except in one important feature. Trained staff were much more directional in the work orders that they gave and in recalling information about patients from the students. Furthermore, apart from the junior staff, a group of four patients was allocated to one nurse, rather than to pairs of nurses. This had important consequences,

particularly for first ward students on Edale and other wards.

For example, because first warders were recognised as requiring supervision they were often allocated to work with eight patients and a staff nurse who might then 'get called away, and you're left with twice the number of patients'. First ward students frequently mentioned this problem, which the researcher also observed. However, this situation did not cause concern for one of them:

... because I could have help if I ever wanted it ... like a third year might take over some of my patients as she didn't have so many.

Junior students most frequently described working with third year nurses. However, within three days of working on the ward, first ward students were observed to be working on their own in direct contact with patients, even if they were allocated to work with more senior staff for a group of patients.

At the beginning of her second week on the ward the student quoted above looked after nine patients with a third year student. The third year student was going off duty at lunchtime, with the result that the first warder, who had been on the ward for less than ten days, was reporting alone on nine patients. The researcher later overheard her confiding to colleagues that she had felt embarrassed. She also seemed quite pleased with herself that she had managed to give the report. The senior staff nurse told the researcher during the same week that she was satisfied with the first warder's performance, whom she described as 'sensible'. She also said that she would feel confident to allocate patients such as A (a young drug user prone to respiratory arrests) to her care.

The other first ward student allocated to Edale ward at the same time described herself as 'an unconfident person'. Perhaps because of her 'lack of confidence' she liked to look after the 'self-caring' patients and 'fill in their charts'. Her 'sensible' set colleague, who

appeared much more confident, found 'a lot to do' for elderly patients who might be 'incontinent two or three times in a morning'. It was one such patient that she had looked after for eight days running because she had chosen to do so when asked by trained staff to state her preferences.

Another first ward student being interviewed after two days on the ward had expected to be used as a 'spare' and was surprised and pleased to find 'you just did more for yourself, you used your own initiative'. She illustrated not only the use of initiative but also the problems of short term patient allocation in the following account:

One day you might have certain people and the next you have different people to look after and the ones you had the day before thought of you as theirs and they get a bit upset. One of them did yesterday, because I was washing somebody else and not them. So I had to make an effort then when I had finished ... to go over and talk to him for about twenty minutes because I had nothing else to do.

The taking of nursing histories and writing of care plans as an integral part of the nursing process were also observed on each ward. On Edale, as on the other study wards, students, irrespective of seniority, admitted patients, took their nursing history and wrote their care plans. Except for the first ward students, there was no routine for the admission history and initial care plan being carried out under supervision.

On Edale ward, although the sister and trained staff discussed the patients' care on a daily basis with the students, care plans were not regularly updated. The weekend was seen as a time when this could be done. Third year students were observed to supervise first warders taking nursing histories. After four weeks on Edale ward, a first warder felt confident to take nursing histories but said: 'I've still not got the hang of nursing care plans'.

A third year student's view of the nursing process, documentation and patient allocation on Edale ward was:

No one seems to use care plans. They (the trained staff) write in a big diary rather than the kardex, which is then carried round by the staff nurse. They don't get involved with patients as they have new ones every day.

6.2.2 Management style on Windermere ward

(a) Sister and staff nurses' ward management style

These findings are based on field observations and an interview with the sister during which she also completed Pembrey's (1980) checklist of daily work priorities.

During the first half of the period that the researcher was on the ward and for some months prior to that, there was a shortage of trained staff on Windermere ward. At the time that the research began on Windermere there was only the sister and two permanent staff nurses in post rather than the recommended establishment of five. They had been working together for about six months. They were joined, after the researcher had been on the ward for three weeks, by two newly qualified nurses and a former 'agency' nurse who became a member of the permanent staff.

During the interview, Sister Windermere explained her role as one of 'listening to, advising and teaching staff nurses'. It is not surprising therefore that she volunteered to be one of the first facilitators for the District's Staff Nurse Professional Development Programme.*

Sister Windermere saw herself as also providing a 'nursing role model' for all nurses by doing drug rounds and providing nursing care which included such priorities as communicating with and feeding patients.

* The Professional Development Programme for newly qualified staff nurses, within the district health authority, had been running since November 1983. The six month day-release course was organised by the department of continuing nurse education. The course aimed to support participants during their transition from student to qualified nurse. A number of ward sisters acted as facilitators to staff nurses on their wards who were on the course.

This was especially important on a ward that admitted a high proportion of physically dependent elderly women.

One of the reasons for the staff shortages on Windermere ward was that it was not a popular choice for newly qualified staff nurses. As discussed in chapter 5, few nurses enjoyed working with dependent elderly people in the acute ward setting. The staff nurses who were recruited to Windermere ward had for the most part worked there as senior students. They applied to work on the ward because they valued the sister's management style and work priorities. However, they found the workload demanding and were worried that they never seemed to be getting through the work. One staff nurse told the researcher that:

You nearly always go off duty not feeling you've done everything. You often wonder whether it really is because of the amount of work you have to do or the way you organise it.

It may be inferred that this staff nurse found difficulty in shifting her aims from seeing her work as a series of physical tasks to be completed rather than as ongoing relationships with patients.

Another staff nurse who appeared to share the sister's work priorities was frequently identified by students and patients as being outstanding for the warmth and understanding she offered them. The researcher observed that this staff nurse spent a significant amount of time when on duty talking to patients. When she was asked why she organised her work in this way she replied 'it's essential'.

During the period when the researcher was on the ward, the trained staff did not take set refreshment breaks together in the office. Perhaps because of this, students used the office freely for their own breaks. Sister Windermere's personal preference was to go to the dining room for meals rather than stay on the ward throughout the shift. Many of the more junior members of trained staff appeared frequently to miss meal breaks. The staffing situation was aggravated by the fact that the sister was undertaking a course of study which took her away from the

ward for one day a week. One of the staff nurses observed that this reduced the amount of 'overlap' time between staff nurses and the sister, during which they could discuss the ward and offer support to each other.

A communication diary was available to all grades of staff for recording comments and suggestions on ward organisation. Two third year students, for example, complained about not getting off duty on time. Perhaps this is what one staff nurse meant when she said the diary comments could develop into a 'slanging match'.

The way in which the sister and staff nurses worked with doctors, as an indicator of management style, was noted. Trained staff accompanied doctors on their ward rounds and attended meetings organised by the geriatricians and one of the general medical consultants to discuss patients' social problems. The sister also said that she saw 'listening to and advising junior medical staff' as one of her daily jobs, which she added to Pembrey's checklist of work priorities.

Unlike the other study wards, there was little socialising on the ward between doctors and trained staff during coffee and tea breaks. Since such breaks among trained staff were not so much part of the work culture as on other wards, the medical staff did not have a 'social' reason for visiting Windermere ward.

A newly qualified staff nurse complained that the doctors were very hard to make contact with. She quoted a recent incident when they had made a decision about a patient following a ward round. They then left the ward without informing her of their decision. This situation may have arisen because of her relative inexperience in not following through the decision making process with the doctors. However, a similar situation arose on a number of occasions, especially when the patients were admitted to Windermere ward under the care of a consultant whose allocated beds were usually on other wards. Such

situations suggested that a number of doctors did not have a close working relationship with the trained staff on Windermere ward; nor did they see keeping them informed of medical duties affecting patient care as a top priority. These speculations were supported by the sister's identification of two work problems associated with doctors on Pembrey's problem checklist and presented in chapter 5, table 5.2 (p.248). The first problem, 'doctors not giving patients enough explanation', was shared with two other sisters from the study wards, but Sister Windermere was the only sister to identify 'the number of separate medical rounds in a day' as a work problem.

(b) Students' views on ward management style

Questionnaire comments presented in chapter 5, section 5.4.5(c) (p.297), on causes of stress or anxiety (Question 37) on Windermere ward, suggested that the nature of the work and lack of trained staff, rather than management style, created stress for students. However, the interaction between management style and workload in creating stress is illustrated by the respondent quoted below (section 6.3.3(a)), who found that the sister's emphasis on communication with patients and the volume of the physical workload made her feel that she was not doing her best.

The positive features of Sister Windermere's management style are summed up in the responses to Question 41 in the questionnaire which sought 'other comments about the ward':

Nurses are able to express 'humour', which I feel is sadly lacking on some wards between staff and students !!! (Student at end of Module 3 allocation)

Commenting on the 'desperate need' for more staff, a student at the end of her twelfth module stated: 'Thank goodness for the extremely supportive trained staff!'

It was noted in chapter 3, section 3.3.5(a) (see p.133), that during participant observation the researcher experienced Windermere ward as

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having a relaxed atmosphere. All the nurses except the sister were on first name terms. Sister Windermere had a friendly and informal manner with students, as did the staff nurses. However, not all students experienced the atmosphere and social relations on Windermere ward as relaxed. Two third year students spoke frankly to the researcher at the end of their module 14 allocation. They had found difficulty in accepting the sister's work priorities, which emphasised affective care and the need to do emotional labour, given the demands of the physical workload on the ward at that time:

There are two sets of staff on that ward: those who are organised and those who are not. Their priorities differed and some shifts you really hated. Sometimes you felt you were thinking for the qualified staff.

They gave one example of reminding the sister of the need to prepare and administer the intravenous injections. According to the students, the sister frequently forgot to do them on time. One of the students continued:

It's all very well talking to patients. But other patients have needs as well. There are things you just need to get done (refers to bed baths and observations).

The other student joined in the account:

Trained staff allocate themselves to work with patients and then they get diverted to do other things. It would be better to know where you stand. It's perhaps just too relaxed and it's difficult for the first years as there is no teaching. Also the patients get frustrated.

Both these students later went on to be staff nurses on wards that had a reputation for being tightly organised. One of these wards was Ronda and the researcher met one of the students a few months later whilst on that ward. Her reactions to the management style of Sister Ronda are discussed in section 6.2.3 below.

However, another third year student who, like the other students, had been on Windermere ward at the same time as the researcher thought that although the ward was 'disorganised', because the sister 'really does seem to care about the patients', she felt she cared more too.

This same student also thought that Windermere was 'a brilliant ward to do for your first ward because the staff are so nice and friendly and you get on really well with them and you're not scared.' Thus, not only was Windermere ward regarded as a 'good' ward for first year nurses because of the nature of the work (chapter 5), but also because of the management style of the sister. However, a first warder qualified this view in the following way:

I haven't really seen Sister very much ... I don't think she is quite so approachable (as the other staff). But she is very nice when you ask her anything, although she always seems so busy that you don't really like to.

For this reason the first warder said that she was more likely to ask the staff nurses or third year students if she needed to know anything. It may be inferred that even when the sister operated a management style that was relaxed and friendly, the hierarchical nature of the social relationships in nursing still made it difficult for a first ward student to approach her rather than nurses lower down in the hierarchy.

Another first warder observed that a temporary staff nurse who was working on Windermere ward changed the whole atmosphere because 'he's such a laugh and he's very good with the patients'.

It was most often those third year students who agreed with Sister Windermere's work priorities who appeared best able to appreciate her management style. During a critical incident discussion in the school (see chapter 4, p.181) following their module 12 allocation, students were asked to give examples of communication between trained staff and learners on the wards. A student who had recently been on Windermere described the sister as having 'a team approach to care'. When asked by the tutor to explain what she meant by this she replied that not only were students encouraged to use their initiative, but the sister actively sought 'expert' nursing opinions from nurse specialists such

as the senior sisters on the geriatric and neurology wards and the oncology nurse counsellor.

(c) The interpretation of the nursing process on Windermere ward

On Pembrey's checklist of daily work priorities (table 6.1), Sister Windermere awarded two ticks to supervising patients' meals and asking nurses to report on their work. She thought that working with students and giving nursing care to patients, although important, could be delegated to the staff nurses. As noted above, she did however see her role as 'listening to, advising and teaching staff nurses' and providing all nurses with a 'nursing role model' through personal contact with patients. She also liked to plan students' work with them rather than 'giving the report', so that they could be involved with trained staff in one-to-one communication and interchange about patient care. The sister did not indicate on the checklist that she did a daily nursing round of patients. Rather, she used the drug round as a way of seeing every patient daily, but added that she would talk in depth with and listen to selected patients and relatives only, depending on need.

As stated above, Sister Windermere had a reputation in City hospital for commitment to the nursing process. She delegated responsibility to other nurses and made them accountable to her through the lunchtime handover reports.

The ward day was organised in the following way. All nurses took the night report. For purposes of allocating the work, the ward was divided in either halves or thirds depending on how many nurses were on duty. The dependency of the patients was reflected in the beds they occupied in the ward. The four bedded bay opposite the nurses' station was for high dependency patients, who were likely to be elderly and often physically and mentally dependent. Junior and senior students were allocated in pairs to each group of patients. Sometimes one nurse, depending on her experience, would be allocated to care for a group of

patients on her own. In many ways, therefore, the allocation of patients to nurses and nurses to nurses in order to give care did not vary significantly from the other study wards.

Students were given some choice as to which patients they were allocated and for how long. Over a one month period, one of the staff nurses monitored the patient allocation. It appeared that there was a tendency for the first year students to stay with patients for longer (on average for three days) than students in their final year who changed their allocated patients more frequently. To some extent this was influenced by their perceived need to gain management experience for their assessments in module 12.

On one occasion a patient asked a third year student who had looked after her on the previous day if she could look after her again on that day. The student agreed, requesting the same group of patients that she had looked after the previous day when the trained staff were allocating the work. The patient who made the request knew Windermere ward from previous admissions and was familiar with the system of nurse-patient allocation.

Sister Windermere was observed to differ in one important respect from the sisters on the other study wards, in the way she organised the giving of work orders and reporting on care given. After taking the handover report from the night nurse, each nurse or pair of nurses who were caring for a group of patients were given a detailed report so that they could discuss the care plans for that shift with a trained member of staff. While one pair of nurses discussed the care plans, another pair would dispense drugs for their allocated patients.

Students found the sister's method of handling information time consuming and perceived it as taking up 'valuable time' when they could be 'getting on' with caring for patients. One first ward student explained why the report might take so long. If the sister or staff

nurse were called away during this discussion, then the students were not able to begin caring for patients until she returned to complete the discussion. During participant observation nurses were frequently heard to complain because they rarely began their morning's work before 9.45 am.

Furthermore, the sister encouraged the nurses to prioritise their work in a different way than was usual on other wards. She did not see 'getting the beds, baths and washes done' during the morning as vital. She thought they could be completed in the afternoon. She considered observations of vital signs and pressure area care should be completed before commencing other care for patients.

As the sister liked the nurses to start writing the kardexes at midday, this left very little contact time to get through the work, in the nurses' eyes, since they still insisted on finishing all the baths and beds in the morning. The students were expected to finish their work at midday and write their kardexes in order to give sufficient time to prepare for the handover with the afternoon shift at 12.45 pm. Each student reported on his/her patients. The nurse in charge orchestrated the report and updated the care plans. Certain phrases used were challenged and discussed, such as 'demanding patient', 'self caring', 'patient reassured'. This strategy appeared to reduce the tendency to give negative labels to patients and remove legitimation for nurses to withdraw emotional labour as suggested from classroom discussion described in chapter 4, section 4.3.2 (see p.180).

The following statement from a first year student illustrates how Sister Windermere supervised report giving:

Sister always stressed talking, and it was the things you said rather than what you did ... like (referring to conversations with patients) 'she said such and such'. You couldn't just say 'encourage'.

The student, a first warder, was doubtful whether this approach was helpful and described it as 'a bit picky'. On the other hand she

described the ward and the kardexes being 'totally geared' to the activities of daily living, which she thought was 'really good'.

Nurses would add to their kardexes throughout the shifts if there were any changes. Trained staff handed over to the night staff.

As discussed above, third year students found difficulty in following the sister's work priorities. One student who was about to take her finals said:

Sister is atypical. She emphasises communication. She doesn't mind if you sit and talk to patients and don't get the bed baths done.

Another third year student, however, still felt that there was no time to give emotional support to one of her allocated patients because she perceived the need to 'get the washes done'. The finalist added that because the sister was:

... very psycho-socially based, you feel bad if you can't talk to them (the patients) as she (the sister) expects it.

Another student's questionnaire comment to question 37 on causes of stress confirmed this view. She wrote that the sister's management style, which emphasised communication, was stressful because she felt guilty at neither completing the workload nor giving 'maximum time to talk to patients'.

These views correspond with Fretwell's (1985) findings on ward stress and anxiety which demonstrated that nurses experienced stress on wards where the sisters' management styles encouraged them to give emotional support to patients.

A third year student in module 12 who 'enjoyed the ward' was of the opinion that the sense of never having achieved what one hoped to achieve on Windermere ward came from 'disorganisation' rather than 'hard work'. When asked why this was, she proceeded to compare the type of patients to those in the district's longstay geriatric hospital. When she was doing her placement there, and if she had the opportunity, she would always insist on working in pairs because of the need for two

nurses to lift and turn heavy patients. She described how one morning on Windermere ward she had worked in a similar way with one of the staff nurses:

We worked down one end and everybody was bathed ... everybody had their hair washed who wanted to and the ward was absolutely spotless ... we were actually getting them bathed without them being told 'oh yes, you can have a bath; do you really want a bath? Could you have a bath this evening?' and nobody gets a bath in the evening - it's ridiculous. We really felt we had achieved something. The patients were happy and we were happy.

The student was describing a task orientated approach to care even though she had been allocated to look after a group of patients. This corresponded to Evers' (1981a) description of 'warehousing' geriatric patients. On this occasion, the warehousing could be described as 'semi-personalised' since the student said that patients chose whether they had their hair washed. The choice over the timing of their baths, however, appeared to be dictated by the student wanting to complete the patients' hygiene, by the end of the morning shift.

A finalist was observed caring for a group of four high dependency patients on her own. She was seen to interrupt her care of one patient seven times in 45 minutes as she called for help to lift and turn the patient or was called away to bring the commode or collect another patient from the toilet. She remarked to the researcher that this was taking patient allocation 'too far'.

Another example of conflict between a student's and the sister's priorities for patient care is illustrated in the following observation made to the researcher by another finalist. About M, a severely demented patient, she said:

I think I'm a patient person but, really, it's got too much. Staff nurse said sister wouldn't let her (M) be sedated. She's detracting attention from the other patients. She just needs someone with her the whole time.

During the interview at the end of her allocation to Windermere ward, a first ward student said:

Sister is really into her patients. She's a lot more into the patients than the nurses. She's a lot more interested in the patients. She's tremendous to the patients. You have to do everything for them and the report lasts three quarters of an hour and you're dying to get off!

It will be noted from the above accounts that students frequently reacted to the sister's management style and interpretation of the nursing process, which put patients rather than tasks at the centre of care, as a sign of being 'disorganised'. This observation matches De la Cuesta's (1983) findings that the perceived absence of routine on a ward was equated with chaos and incompetence in the eyes of other nurses. Similarly, inferences can be drawn from Baker's (1983) study of a geriatric ward where two styles of patient care were in evidence. A new ward sister's attempt to individualise care and put patients' needs before ward routines met with opposition from other ward staff, who valued getting through the work as quickly as possible. In their eyes, involving patients and putting their needs first wasted time.

In terms of patient allocation and nurse contact on Windermere ward, once the nurses were allocated their patients it was up to them to decide whether they worked together or independently. Usually first and third warders were allocated to work with third year students. Occasionally, third warders (i.e. first years) worked with first warders if there was no alternative.

The consequences of nurses working alongside each other and sharing out patients between rather than together is illustrated by the following vignette. A third year student and a first warder had been allocated patients to look after together. One of their patients was an elderly lady with two wounds: a healed leg ulcer and a discharging abdominal incision. At the lunchtime report, the trained nurse in charge asked for a report on the state of the wounds. It became apparent that the first warder had cared for the patient alone. The third year student had not assessed the care required by the patient,

with the result that the patient's abdominal wound had been left uncovered by the inexperienced first warder.

Third ward students could also be given a group of patients to care for on their own. During participant observation the researcher noted that a third warder had been allocated ten patients to care for. She organised her work well but there was too much for one person, as she commented to the researcher at the end of the morning's work. Consequently two elderly sisters, who needed a great deal of psychological support and reassurance, did not get the attention they required until the afternoon when they were escorted by the student to the dayroom.

If students were allocated to work with trained staff a problem occurred which was described by third year students above and also by students on Edale ward. The trained staff got caught up in administrative tasks, leaving students to carry out their allocated work alone. A first ward student described the consequences:

One of the girls was with sister ... she didn't like that very much because ... she would keep telling her what to do and then whizzing off again. I thought that was really hard.

During one unusually quiet weekend the sister organised the nurse-patient allocation in the following way. The patients were divided into three groups to include a dependency mix of low, medium and high. For each group a senior and a junior nurse were allocated: the sister with a third year preparing for a management assessment, the staff nurse with a third warder, and a third year student close to finals with a first warder. Within each group of patients the most dependent one was identified by the sister, and a named nurse was allocated to his/her care.

The taking of nursing histories and the writing of care plans as an integral part of the use of the nursing process on a ward were observed. Students, irrespective of seniority, admitted patients, took

their nursing history and wrote their care plans. However, as noted above, the care plans were regularly updated by the nurse in charge during the lunchtime report. The admission history and initial care plan were not carried out under supervision. Usually new students in their first few weeks on the ward were informally supervised by third year students. The sister and trained staff, however, discussed the patients' care on a daily basis with students before they began their work. On one occasion observed by the researcher, the sister took an admission history with a third warder.

Although the sister was very committed to the nursing process, the supervision of history taking and the initial care plan was still often left up to third year students to supervise. First warders were observed by the second half of their allocation to be taking histories on their own.

6.2.3 Management style on Ronda ward

(a) Sister and staff nurses' ward management style

The findings presented below are based on field observations and an interview with the ward sister, during which she also completed Pembrey's (1980) checklist of daily work priorities.

Ronda was a popular ward with newly qualified staff nurses and there were always plenty of applicants for the vacancies that occurred periodically. The staff nurses stayed, on average, about a year, except for the senior staff nurse who viewed her post as a long term appointment. At the time of the study she had been on the ward for eighteen months. Often the staff nurses had worked on Ronda ward as senior students and had decided then that they wanted to return after passing their final examination. Reasons for returning were a mixture of liking the sister's style of management and the type of patients (ranging, as one prospective staff nurse put it, 'from the elderly to the acute GI (gastrointestinal) patients').

The sister always took coffee and tea with the staff nurses when many informal discussions about patient care took place, often with the doctors. As discussed below (section 6.2.3(c)), trained staff always had their own report before the general handover with all the staff. The sister was also interested in the professional development course for staff nurses in the district, and was one of the first facilitators. She always had one staff nurse attending the course.

A junior staff nurse summed up the sister's management style in her comments that Ronda was 'a laid-back ward; patients like it' and 'that's why I wanted to come back having worked here as a student'. The staff nurse's comment also captured the atmosphere of the ward as experienced by the researcher during participant observation. The sister was efficient, technically competent, well organised, and involved herself in direct patient care. The same staff nurse quoted above went on to say: 'You were one of the few sisters I saw as a student who did any nursing'.

Sister Ronda told the researcher that she considered it the students' responsibility to make sure that patients' needs were met. She gave the work orders during the handover report and then she considered that the follow-up care was the responsibility of the students. She would undertake any omissions in care herself rather than ask students to do so. A junior staff nurse described a management approach similar to the sister's when she said:

I don't like telling students what to do. I prefer to set an example by doing the work myself.

There was no priority explicitly given to affective patient needs on Ronda ward, and the sister's ability to distance herself was reflected in her strategy of having a set routine when she took breaks for drinks and meals. It was also a measure of her organisational ability that she could say, and was observed to, 'never miss my break no matter how busy

we are'. Many of the researcher's informal discussions about the sister's views on nursing were held during those breaks.

For example, during one coffee break Sister Ronda described an experience which seemed to offer one explanation for her implicit rather than explicit prioritisation of affective nursing and investment of emotional labour. As a newly qualified staff nurse she and her friend had become emotionally involved with a young patient who was dying. Whilst she was sleeping, following a night shift, she had what she described as a 'psychic' experience. She was aware that the young patient was in the room. Later she found that her friend had had a similar experience and that it was about the time the patient died. After that, she said, she had resolved never to get so emotionally involved with a dying patient again.

Indeed, rather than invest individual emotional labour the sister often referred patients' psychosocial problems to the social work department. She also derived support from doctors in the joint care of patients with poor prognoses, as described below.

The sister worked closely with all grades of doctor on the wards and particularly with the consultant. They appeared to have a mutual respect and high regard for each other's work. The only criticism expressed by the sister was that the consultant preferred to communicate with her and not with the staff nurses. The other doctors, however, were seen to be 'very good on this ward at keeping in touch'. This was certainly the researcher's experience, and from observing management styles on four wards, it seemed that the sister and trained staff on Ronda ward were the most explicitly doctor orientated. Much of their informal communication was carried out during coffee and tea breaks.

The sister also frequently emphasised the importance of a trained nurse, usually herself, being present when a doctor told patients their

diagnosis, so that she knew exactly what was said, particularly in cases of cancer. The sister's emphasis on being present when doctors told patients about their diagnosis was consistent with her identification of 'doctors not giving patients enough explanation' on Pembrey's problem checklist (table 5.2, p.248).

Because many patients on the ward had a poor prognosis, the researcher asked the sister if this upset her. She admitted that it did, especially if the patients had been coming to the ward over a long period. The sister was then asked from whom she got her support. She had no hesitation in replying that it was from the doctors. The consultant had also supported her recommendation to the nursing and hospital administration for an extra staff nurse. Sister Ronda explained that she saw the consultant as her main supporter and reference point, rather than the senior nurse for the gastroenterology unit. A house officer finishing his allocation on Ronda ward came to say goodbye and expressed positive feelings about his time there: 'It's been a good ward,' he said.

(b) Students' views on ward management style

Questionnaire responses to causes of stress or anxiety (Question 37) on Ronda ward suggested that management style played some part in creating stress for students but in some instances reduced it. For example, a first warder found the trained staff 'always helpful and relieved any anxiety'. However, a third year experienced 'a personality clash with sister' and another respondent commented that stress was caused when the staff did not inform her of a patient's death on return to the ward after being off-duty for some days. She also added a comment categorised as 'affective' that was associated with management style as an underlying cause of stress which in turn produced feelings that generated stress. Trained staff (rather than the sister) were said to have panicked, which, she wrote, made students

'feel unsure of their work'. Features of Sister Ronda's management style are summed up by a first year respondent to Question 41 on the questionnaire in the following way:

There is very poor communication between trained staff and students. Often when writing kardexes at the end of a shift, you would be told you had written something wrong when actually you hadn't been updated on a patient so you could not write what had changed for him. (First year student at end of third module allocation)

Although a third year student also commented that she thought that students should take more part in patient handover using the kardex and care plans, she still felt able to state that Ronda 'was the most enjoyable medical ward I have worked on. The staff were totally approachable.' She also added that 'the housemen and registrars were approachable and informative'.

That stage of training was important in terms of appreciating the management style in operation on Ronda ward is summed up by a student in module 14:

I think I enjoyed the ward more as a third year as there is a need for using initiative and self confidence which you may not have at the beginning of training.

Interview and field data offer further insights to the questionnaire comments on students' views of management style on Ronda ward. The sister encouraged students to call each other by their first names. One third year student said 'I always think it's nice to have a pleasant atmosphere where everyone is relaxed, and first name terms'. She described why she enjoyed Ronda ward so much: 'It's not a rigid routine ... it was organised and efficient ... and the patients were always relaxed and happy'.

A senior third year student, who found Sister Ronda's style of management preferable to that of Sister Windermere, thought that because the former 'ran the ward so well' it left time for students to use their initiative to do 'extras for patients' like talking to them. This tendency to describe 'talking' as an 'extra' or something to be

done when all other 'work' was complete was a common orientation amongst many trained nurses and students, and not specific to those working on Ronda ward. Since Sister Ronda's work organisation did fit in with most nurses' orientation, third year students particularly valued being able to get through the physical and technical patient care quickly and efficiently. When the physical and technical work was over, however, nurses were observed to spend long periods of time talking to each other rather than to patients.

The sister was admired by students both for her knowledge of the specialty and for her 'hands on' approach to care. A third ward student, whilst appreciating the sister's involvement in direct patient care and specialist knowledge, found her to be 'casual' about the drugs round. She described her in the following way:

Sister was very casual on the drug round. She wouldn't wait for the patients to take their drugs, which is quite important ... She was a very nice, sweet person; she would muck in with everything ... (and) ... she was good on her subject.

It was observed and confirmed during interview that the third year students worked closely with the trained staff and they in turn worked closely with the first year students. A third warder, for example, explained that she found the third year students 'easier to approach than some of the staff nurses'. That the sister as well as the staff nurses appeared unapproachable, in the eyes of a first year student, is illustrated by the following vignette observed by a module 14 student:

Sister was standing next to me during a drug round and a first year came up to me and she said 'could you tell sister that so-and-so's temperature has gone up?' ... Sister ... she just died! She said 'I think she's a bit scared to talk to me, don't you?' so I thought I had better have a word and say 'well, sister won't bite you!' But then there must be some kind of awe still for the first years. I mean I remember feeling frightened of the sister when I first started, but you forget quite easily.

However, a confident and competent module 12 student, who was on the ward at the same time as the researcher, described the sister and senior staff nurse as 'very approachable' and she herself felt valued

as a team member who was able to contribute suggestions towards nursing care which were later implemented.

(c) The interpretation of the nursing process on Ronda ward

As presented in table 6.1, the sister on Ronda ward responded to Pembrey's checklist of work priorities in the following way. Every 'daily job' was identified as a priority and five out of the ten jobs were deemed 'most important'. Drug rounds were also identified as another task that one would undertake daily.

The sister described 'nursing of patients and supervision of learners' as aspects of her work that she would like to give more time to. As described in section 6.2.3(a) she was observed to give nursing care to patients on most shifts, in accordance with her view that caring was not 'paperwork'. Often her work comprised a series of tasks rather than looking after a group of patients. Sometimes these tasks were dictated by national and hospital policy, such as the administration of intravenous drugs that could be given only by a trained nurse who had attended an in-house course.

She usually dispensed the oral medications, often with a staff nurse, and used this as a way to see patients. When she could, the sister enjoyed performing tasks such as dressing wounds or removing chest drains. In addition to performing these technical tasks she told the researcher that she was (and was observed to be) committed to helping at least one patient with his hygiene, toileting or mobilisation during the course of a shift.

Sister Ronda had trained in a hospital and staffed on a ward that had practised the nursing process when it was first introduced to Britain. During a coffee break discussion with the sister and two recently qualified staff nurses about the nursing process, the following points emerged. The staff nurses who had trained at City had no notion of the old system of task allocation. 'What's a back

trolley?' they asked. The sister, however, felt that standards of nursing care had fallen in some respects since the introduction of the process.

The sister's apparent ambivalence about falling standards since the introduction of the nursing process perhaps explained why she adapted the way she used it to allow her to maintain control over decisions about patient care with respect to allocation of the work and the handling of written and verbal information. The way in which she maintained control was illustrated by her response to Pembrey's checklist of work priorities in which every job was a priority, and students' comments that written and verbal information about patient care was controlled by trained staff.

The nursing work was organised on Ronda ward in the following way. Firstly, it was always allocated in the same way at the beginning of the shift. Nurses were offered choices over which patients they looked after. The ward was divided by layout, and a senior and junior member of staff were allocated to each division. It was known that certain types of patients would occupy particular beds in specific sectors of the ward. Low dependency patients, therefore, would occupy the balcony and non-single side rooms. Patients requiring isolation would be in the single rooms, and high to medium dependency patients would be in the main ward. Where possible a trained member of staff would be allocated to work with students; failing that, a third year student worked with a student in her first year.

The tendency on Ronda ward to get the work done rather than emphasising true patient allocation is illustrated by the following comments by the sister:

One problem I've found is that students tend to stick to their own patients and don't help on the other side (of the ward).

I'm a sister who likes 'to do' - I can't sit still.

This tendency is also illustrated by the following field observation. A

third year student, who had been allocated to look after a dependent elderly patient with communication difficulties, returned from making the beds of her allocated patients in the side wards to find the sister already bed bathing this man. 'Sister's great,' she said. 'She always gets in there and usually does the most difficult patients.'

Meanwhile the researcher, who had also been allocated to look after this patient, felt irritated that they had not been permitted to get on with their own work in the way it had been planned, thus undermining the principle of the nursing process.

Written and verbal information was also closely controlled by the sister. Before the open handover of information, the sister or staff nurse (i.e. whoever was in charge) took the report from the person who had been in charge on the previous shift. Students were then assembled for the open handover given by the person in charge. It was a one-way transaction during which nursing orders were given for the nurses to perform for the patients during the course of the shift. A comment in the researcher's fieldwork notes reads:

On the whole a very silent exchange: nurses with heads down, scribbling; trained staff only giving information. Few comments made by students. For feedback, trained staff asked to be notified of any changes in patients' condition.

It is possible that the way in which Sister Ronda conducted the nursing handover report led to the use of language that stereotyped patients. Patients were described in such terms as 'self-caring'; 'a sweet man'; 'no trouble'; or 'just a social problem'. An interesting term that was used to describe the behaviour exhibited by patients being treated for cancer in protective isolation was 'four-walls syndrome', i.e. depression, irritability and feelings of going mad.

The use of language to stereotype patients confirms students' classroom accounts of the emotional labour process presented in chapter 4, section 4.3.2 (p.178). For example, the emotional trauma of cancer

patients in protective isolation was dispelled by labelling their reactions as a 'syndrome'.

On the morning shift students usually wrote their own kardexes. However, if they had been working in pairs it was possible for one of the nurses to write the kardexes for her colleague. In the evening the trained member of staff wrote up all the kardexes. Students never verbally reported on their patients nor were present when the information was handed over for the patients they had looked after during the shift. This system of verbal handover had been in operation only for a short period.

A staff nurse hoped that they would go back to students handing over their patients as they had done in the past, because 'they took more interest and wrote better kardexes when they had to report on their own patients'. The reason given by the staff nurse for the change in the system originated, she said, during a very stressful time on the ward relating to a patient who was suffering from leukaemia. The trained staff had felt that the students were under too much stress to have to write and hand over their patients. The sister's reason for change in the handover system was that third year students had complained that it took too long and made them late to go off duty.

As described above, the limited reporting system was frequently criticised in the questionnaires (5 out of 9 students). Students criticised the handover report, on the one hand because it was not used for teaching purposes, and on the other because of the problems of exchanging information between trained staff and students.

During interview, a third ward student described the consequences of the limited reporting system by saying 'I think it can go totally over you if somebody else is doing the report'.

A more serious consequence of the controlled reporting system was described by a first year student, who said:

There's a quick turnover (of patients) and the thing I particularly noticed (on nights) ... let's say one person has been discharged home, and you probably nursed them all the time you were on there; well, you don't know they have gone and they (trained staff) just say 'well..' when you ask where he's gone. Or somebody may have died, and as another girl was saying she looked after somebody for six weeks and they died (while she was on her nights off) and she felt cheated that they hadn't actually told her ...

During a classroom discussion, reported in chapter 4, section 4.3.2 (see p.181), students made similar observations about feeling cheated when a patient's death was not acknowledged by trained staff.

On night duty there were only two nurses for 23 patients, and so the work organisation was predominantly task orientated. The junior nurse wrote down a long list of observations to be done and specimens to be collected, and worked her way through the list as the night progressed.

Patient allocation and nurse supervision was practised on Ronda ward in much the same way as it was on other wards, i.e. senior and junior nurses worked in pairs looking after a group of patients. On the other study wards, however, one nurse was sometimes allocated to work with a group of patients, but this rarely happened on Ronda ward. It was likely, however, that the work was divided between the two nurses, each caring for individual patients independently. After only two days on the ward, a first ward student described the work organisation in the following way:

We usually worked by dividing the ward in half and with another nurse (third year or staff nurse). It was only a third warder if there was no one else.

When asked if the nurses worked together or alone, she replied:

I was working with them, really (on the first day) ... On the next day I was working with a different student (third year) and we did some patients together and one each.

The researcher also observed that two first ward students very quickly began to care for patients on their own. After three weeks on the ward one of them felt 'confident' to look after dependent elderly patients alone. The other preferred to take an admission history rather than care for a demented elderly patient. The students were supervised by a

module 12 student. The researcher observed that the first warder who felt confident to care for elderly patients appeared committed to caring for one such longstay patient throughout her ward allocation. The student was able to give some continuity of care and consequently formed a close relationship with him. During a bed bath observed by the researcher, his usual apathy gave way to tears as the student encouraged him to talk about his past life in the army.

Students' long term commitment to patients was based on their own choice rather than a system of patient allocation that promoted continuity of care.

Nursing histories and care plans were largely undertaken by students, irrespective of seniority. They admitted patients, took their nursing histories and wrote their care plans. These activities were not usually carried out under supervision. New students in their first few weeks on the ward were informally supervised by third year and even third ward students, i.e. anyone who was senior to them. The module 12 student referred to above asked the researcher to admit a patient with one of the first warders because she 'didn't think she was very good at history taking'. The third year student did however think that the junior's care plans 'weren't bad'. The first warder had been on the ward less than a month! She conducted the nursing history competently and matter-of-factly. She identified that the patient was extremely anxious and tense, and was skilful in turning questions on their head about how long the patient expected to be in hospital and what he expected the outcome of the investigations to be. It seemed likely that he might have cancer. The student did not have time to write up the care plan. As she was off duty for the next two days, she was not likely personally to be able to follow up the interview. This situation

arose frequently, i.e. that the nursing history was seen as a task to perform in its own right, without any continuity of care by an allocated nurse. This phenomenon was observed on all the study wards.

It was rare for trained staff to supervise these activities. Rather, the sister would update all the care plans regularly herself and never with students.

Another student, at the end of her first week on Ronda, her first ward, said:

I actually had to try and admit somebody.

PS: Is that the first time you've ever conducted the (admission) interview?

Yes. Gosh, I didn't do it very well. Someone (a third year) had to help me in the end. But I know how not to do it now, I suppose.

There was no question that by the third ward a first year student should be able to do admission histories without supervision. L, for example, was observed taking a number of nursing histories on her own one afternoon. Again, as on other wards, only first time history taking and care plans were supervised, usually by third year students.

The care plans were routinised. A first ward student described them as 'all basically the same ... everybody uses the same kind (of language), like 'maintain hygiene', and once you've done a couple you know what to put in'. The similarity of language could partly be because the sister used to spend time updating the care plans.

6.2.4 Management style on Kinder ward

(a) Sister and staff nurses' ward management style

The findings presented below are based on data collected during participant observation and an interview with the ward sister, during which she also completed Pembrey's checklist of work priorities.

The sister on Kinder ward was observed to have a clear sense of management and she trained staff nurses to manage the ward by ensuring good written and verbal communication. Each member of trained staff had

a personal diary in which they recorded aspects of ward administration relating to doctors' rounds, patient arrangements, student assessments and anything else of note, including research activities. There was also a ward communication diary left at the nurses' station in which items of general information and relevance to all the nurses were recorded. The researcher, for example, was asked to indicate in the diary when she would be on the ward.

Kinder was a popular ward with newly qualified staff nurses. There were always plenty of applicants for day vacancies, but the permanent night duty post was more difficult to fill. The junior staff nurses stayed, on average, about a year. There were also three senior staff nurses, two of whom had been in post for nearly two years. In line with the specialty of the ward, which also had the coronary care unit (CCU) for the hospital attached to it, the senior staff nurses either had taken a postbasic course in or had experience of intensive care nursing. Two of them had not trained at City hospital. It was not common on the other study wards to have staff nurses recruited from other hospitals.

The ward staff were in a state of flux, influenced by the sister's imminent departure. One of the senior staff nurses was leaving and the other two intended to apply for the sister's post, which was observed to create an element of competition between them.

The sister said she selected staff nurses for 'level-headedness'. They had often worked as senior students on the ward and returned because they liked the specialty. One staff nurse, who had been qualified less than a year, described herself as 'only knowing about cardiology', reflecting a medical rather than a nursing orientation to her role.

Two new staff nurses were appointed at the end of the study period. One of them had been working throughout the research as a senior

student. The sister instructed them on their first day on the ward to obtain their own personal work diary to record information of importance to a ward manager.

Although trained staff shared the ward report with students, they always took their coffee and tea breaks together. This occasion provided them with an informal opportunity to exchange information and ideas.

Staff nurses described their work on Kinder ward as 'hard', because of the dual demands of working in the coronary care unit and on the ward. They felt that their work lacked continuity because of these demands, as well as the interruption of frequent doctors' rounds. The staff nurses were encouraged by the sister to teach the student nurses, which they did in the form of tutorials, rather than practical supervision. Sister Kinder was a facilitator for the professional development course for staff nurses in the district.

Sister Kinder identified affective nursing during ward reports but delegated emotional labour to the staff nurses and students. Her efficiency and organisation appeared to create a calm environment which she reinforced by selecting those she perceived as 'level-headed' staff nurses.

The sister also told the researcher that she thought it was very important to check that her staff's morale was high through maintaining a 'good' atmosphere on the ward. She was observed to maintain a 'good' atmosphere in a number of ways. For example, she would frequently buy confectionery of the nurses' choice to have with their morning coffee. She used ward funds to do this. One of the patients told the researcher that 'the girls I've spoken to love her'.

Thus her part in the emotional labour process was in the creation of a positive ward atmosphere and maintaining staff morale. The sister also delegated emotional labour to other agencies, such as the social

work department and the chaplain. As noted below, she and the trained staff participated in multidisciplinary team meetings with medical and geriatric consultants.

She was aware that the students did not like being in charge on the main ward at the weekends but she thought it 'did them good'. She left third year students in charge in both the ward and the CCU during the coffee breaks, so that she could take these with all the staff nurses on duty. Hence, although the students could use the office to rest during their breaks, they usually took them independently of the trained staff.

The sister worked closely with all grades of doctor on the wards, particularly those on the two cardiology teams. She always accompanied the consultants on their rounds when she was on duty and encouraged the staff nurses to do the same. The house officers and registrars often joined the trained staff for coffee and tea breaks.

The geriatric consultants held multidisciplinary team meetings, as on other wards, to discuss the long term care of their patients with nurses and social workers. However, the cardiologists did not have such a system of multidisciplinary meetings. They tended to make decisions about patients' care which did not always include the nurses.

For example, one of the senior staff nurses described how during an evening shift whilst she was behind curtains with a patient, another patient, unbeknown to her, was visited by doctors who announced unexpectedly that she was likely to go to the operating theatre for major heart surgery on the following day. They also told her that they would return later to discuss the matter further with her. The doctors left the ward without informing the staff nurse of their intentions. The patient was not revisited and became increasingly anxious and tearful about the proposed operation. The staff nurse, like the sister, was well able to stand up to consultants and other doctors on behalf of

patients and indeed was prompt to follow the matter up by getting in contact with the doctors to find out what was happening. However, doctors on this occasion did not apparently involve nurses in decision making nor keep them informed of decisions taken amongst themselves. In spite of these two incidents, Sister Kinder was the only one of the four sisters studied who did not identify 'doctors not giving patients enough explanation' as a work problem on Pembrey's problem checklist (chapter 5, table 5.2, p.248).

(b) Students' views of ward management style

Questionnaire comments on causes of stress/anxiety (Question 37) on Kinder ward were outlined in chapter 5, section 5.4.5(c). One cause identified by respondents, especially on night duty and during coffee breaks, was when third year students were put in charge in the main ward because the trained staff were in the CCU. One third ward student summed up the situation and its implications for quality of nursing and student learning:

Not always having trained staff on the ward: I felt that sometimes, especially with the first ward students, they were left to fend for themselves to the detriment (sometimes) of patient care and perhaps student confidence.

Features of Sister Kinder's management style are summed up in the responses to Question 41 on the questionnaire, which sought 'other comments about the ward'. The commitment to the organisation of ward tutorials was reflected in the students' comments, but two third years were critical of the system of patient allocation and the reporting system on the ward. A module 12 student commented in the following way:

The ward is a good environment for learning and there is plenty of opportunity for teaching - if this is taken up. Sometimes it is and sometimes it isn't. The major problem is lack of communication. I felt that students had very little chance to speak their views about patient care. This is bad as it was the students who do the actual physical work.

This student was commenting on the ward environment three months before the researcher undertook participant observation. From her point of

view the trained staff were distant from patients and involved in administrative tasks rather than direct patient care. This viewpoint might be explained partly by the trained staff's responsibility for the coronary care unit attached to the ward and the explicitly technical nature of patients admitted for investigations and/or treatment of cardiac and metabolic conditions.

Consequently, third year students appeared to be given more responsibility than on the other study wards for running the ward at night and at weekends. The outcome of this arrangement appeared to be that direct emotional labour with patients which was observed to be done predominantly by first ward students on all the study wards, was even more pronounced on Kinder ward. One explanation as to why first warders undertook direct emotional labour appeared to be that, unlike students from the third allocation onwards, they were not so caught up in the technical aspects of patient care and the concerns of ward organisation and responsibility. This supports findings presented in chapter 5, section 5.3.

Interview and field data suggested that measures had been taken to improve the reporting system on Kinder ward between trained staff and students and to make the former more accessible.

Both first and third year students described the ward atmosphere as 'casual' and 'relaxed'. However, comments from first years suggested a certain uneasiness about some of the staff nurses. One first ward student, for example, described one staff nurse as someone 'who can put you down a lot'. A student at the same stage of training but in the ward a few months later with the researcher thought that some of the staff nurses 'had been (nursing) too long' and therefore were not people she would approach easily. Her set colleague 'wasn't so afraid of the third years' and therefore would ask them in preference to the staff nurses.

A student on the ward prior to the researcher described the sister in the following way:

I did admire sister. She was always there when it counted. She'd always give us support as first warders. She really didn't make you feel stupid and the way she reacted in an emergency ... (said admiringly) ...

Another student (module 14) experienced both the sister and staff nurses as 'quite supportive'. She compared Kinder to Edale ward (her last medical ward allocation) in the following way:

I think the atmosphere was informal (on Kinder) and staff nurses and the sister were much more approachable and you felt you could talk to them and there was ... well, it was much more of a team and people listened to your ideas. It was just much more pleasant.

As on other wards, the way in which students perceived the sister's management style on Kinder was influenced by individual preferences and stage of training.

(c) The interpretation of the nursing process on Kinder ward

On Pembrey's checklist of daily work priorities, as presented in table 6.1, Sister Kinder considered that the most important jobs for her to do were to ask the nurses to report on their work, do a nursing round of patients, and give the nurses a report on their patients. However, she appeared to maintain contact with the patients, not through a separate nursing round but through drug and consultants' rounds, nurses' handover reports and coffee with staff nurses and doctors.

The sister was committed to the general aims of the nursing process. She practised patient allocation and expected students to report on their own patients and share in knowledge and decisions about their future care. She felt that students used their initiative more if they were involved in this way. Sister Kinder did not agree, however, with long term patient allocation because she thought 'difficult' patients might put too many demands on students. Her organisation of the ward day confirmed these views.

All nurses would take the night report. The person in charge would then go through the patient report. For nurses new to the ward the report was a full one and included medical and social details about the patients. Nursing orders were given and information about doctors' rounds, investigations and other activities that the patient might be involved in.

The work was divided by bed numbers and patients' dependency was usually known because of their position occupied in the ward. For example patients in beds 1-4, opposite the nurses' station, were usually high dependency patients. Nurses were often asked who they would like to look after and even whether they would like to work alone or together with a group of patients. When students were on their first ward they were always allocated to work with more senior nurses, at least in the first few weeks of their placement.

At this stage it was left to the nurses to decide on their work priorities. Few nurses were observed to do a round of their patients to assess priorities. These were largely determined by the nursing orders but third year students also had their own view of how to plan their work. The first year students tended to follow their example.

The sister was flexible about getting through the work. She said she did not mind if the four-hourly observations were not taken 'on the dot'. She was concerned, however, that 'on a ward like this' the fluid balance charts were kept up to date. She did not mind at what point the beds were made, but often students would use bed making as a means of 'getting started'. The researcher often experienced making beds as a sort of 'clearing ground' for the rest of the shift and a definite task to be done. It also gave a point of contact with patients.

Although students were expected to organise their own coffee breaks there was an unofficial time by which they should be taken. This meant that sometimes students, in order to fit in their coffee break, might

ask somebody else 'to finish off' their patient. This situation occurred on several occasions when the researcher was asked to complete a patient's bath while the allocated nurse went for her coffee break. It may have been that the researcher was asked because she was usually expected to go to coffee with trained staff, when all the students had finished taking their breaks.

The nurses' tendency to focus on specific tasks rather than on patients could lead them to overlook the toileting needs of the elderly. A patient in her nineties had been too embarrassed to ask to go to the toilet throughout the morning. Nobody checked before the lunchtime handover report began whether anyone needed to go to the toilet. For patients 'who did not like to ask', incontinence could result.

The conflict between getting the task done and looking after one's allocated patient arose between two third year students. The students were informed unexpectedly that J's allocated patient was to go for an insertion of a pacemaker. J went off to check the premedication with the researcher. Another third year student, about to get her state final results, took it upon herself to assist, checking that the patient's nail varnish had been removed. J said under her breath 'I wish she'd leave our patients alone'.

Although all students reported on their own patients, two first warders did not feel that their views on patient care had been taken seriously on two issues. One of them vividly described a patient who was in severe pain which, in her opinion, was inadequately controlled. The researcher asked if she could not use the lunchtime report to secure adequate relief for her. She was doubtful:

You could say she wants 'this' ... I wrote the kardexes ... but you're not there to tell them (the trained staff). I think they just thought she was a nuisance.

It might be suggested on the basis of the questionnaire comments that

this student was on the ward when the inadequate reporting system was in operation, as described by two third year questionnaire respondents referred to above. However, another first warder who was on the ward at the same time as the researcher also complained of a similar attitude, despite field observations confirmed by a module 14 student that the reporting system involved all the staff in an exchange of ideas. The first warder said:

You're not expected to know about people, how they feel ... I found it difficult in report sometimes. They were saying something about B (a patient) and B had just been talking to me and so I started to say, and they (trained staff) looked really surprised and said 'who's in charge (over the weekend)?' and a third year said 'I am' and she started to talk, and I was cross about that.

As described above, students participated in the handling of information on patient care. From the questionnaire comments this did not seem always to have been the case on Kinder ward. As mentioned in section 6.2.4(b), four months before the researcher was on the ward questionnaire comments suggested that there was 'poor communication between trained staff and students about patients'. Trained staff were said by one student to report on the patients amongst themselves only. As stated above, this situation was not observed by the researcher, at any time, but rather the system described by a module 14 student during interview:

On Kinder you had time to discuss the patients when all the staff are there together in a large group, so everybody heard the same story at the same time and could - well, it was just much better ... a lot more ideas coming through.

The work was allocated in a similar way to other wards but the trained staff rarely worked with students except during assessments. At least one of the staff nurses or the sister was allocated to work in the CCU on each shift. The sister said she felt, however, that she would like to give more time to students but found this difficult as she also had responsibility for the coronary care unit as well as the ward. She said that she would occasionally allocate herself to work

with a student but found that she was frequently called away. She therefore tended not to allocate herself to work with students unless she was on duty with a staff nurse who could take responsibility for the running of the ward. Third year students, therefore, usually worked with the junior nurses. One first warder described the work organisation in the following way:

You (the student nurses) get split in two, and I got put with a third year. They just tell you what to do.

During interview, at the end of the allocation, two first warders on Kinder ward at the same time as the researcher said:

We don't get much help ... at the beginning we didn't have a foggiest ... like ... should we do the baths? ... and then you begin to do the beds on your own and someone says 'don't do the beds on your own; it's a waste of time', and then you think 'what shall I do?'

This quotation confirms the questionnaire respondent's comment in section 6.2.4(b), when she wrote that not having trained staff on the ward 'left first warders to fend for themselves'. The respondent was also on the ward at the same time as the first warders and the researcher.

As on other wards, although students were allocated to work with more senior students they could quite soon in their allocation be left to give direct patient care on their own. They reacted differently to this situation. One first warder felt that 'if you did get left you could do better because you wouldn't worry about doing it wrong and you'd do it more thoroughly'. On the other hand another student at the same stage of training said:

It's very hard to say to people 'I can't do this' ... like 'just empty this catheter (bag)'. They (the trained staff) will say 'have you taken a swab?' and you say 'yes' ... but I haven't done it on my own - but it's difficult when you do things on your own because you're not sure.

That tasks, rather than patients, could dominate on Kinder ward is illustrated by another first warder's account of filling in a fluid

balance chart incorrectly. As described earlier in this section, the sister placed great emphasis on maintaining accurate fluid balance charts. At the end of the morning, during which the first warder had been taking her assessment, she was so anxious to fill in her fluid balance charts for her other allocated patients that she recorded that a patient about to go to theatre had had a cup of tea. In retrospect she was incredulous that she:

... could have been so stupid ... I knew she was going for an op, I knew she was 'nil by mouth' (NBM), I knew she wasn't taking food - but I wasn't sure about drink and I was so worried about getting my fluid balance charts done.

This incident demonstrated the need for junior students to be supervised (she was unclear what NBM meant), but also the predominance of tasks over patients.

During interview with two first warders, the role of junior students in providing continuity of care through patient allocation is illustrated below. The patient being discussed was a ninety year old (Miss A), who had recently died.

Student 1 (S1): I got quite attached to Miss A, but she was old and she had to go some time ... it was sad.

PS: One of the patients mentioned how much you cared for Miss A on her last day.

S1: ... I just realised that last day she was in total agony.

Student 2 (S2): You knew exactly what to do ... you'd nursed her much more than anybody else. You were her nurse.

S1: I don't know.

S2: You did. I didn't know what to do.

S1: I suppose I'd looked after her quite a few times.

As on other wards, the decision to become involved with patients was left to the students, as in principle the sister did not believe in long term nurse-patient allocation. A student in module 14 mirrored the sister's views. In response to the researcher's question about the length of time one should keep a group of patients, she replied:

It depends, really, on striking the balance between getting to know the patients well and knowing what's going on in the rest of the ward ... not letting, say, a certain patient ... getting to the point where you are irritated by them - because it does happen if you're working for days and days looking after this person who is aggressive or rude. By the end of it your patience just wears thin ...

She went on to describe the choice given to nurses in deciding which patients they would look after:

Like often in report they'll say 'who looked after so-and-so yesterday?' ... like I'll have a break from so-and-so today and let another nurse look after him or her who hasn't looked after them for a week. I think you've got to do it like that or else ... well, it's just more positive to the patient.

In the afternoon there was an overlap of shifts, meaning that patients would have two allocated nurses. When students were not attending tutorials or study visits they would sit and talk to patients. First year students were most frequently involved in this activity. Third year students would busy themselves with the more technical tasks, such as checking intravenous infusions.

In the evening, when staff were fewer, there was a less clear system of patient allocation. Tasks such as drug rounds and observations were superimposed upon it, especially during supper breaks. However, the students still wrote in the kardex about their patients and reported any changes to the nurse in charge, who then reported to the night nurse.

There was no attempt to allocate patients to nurses on the night shift. Since there were only two nurses on duty, reduced to one during two one hour meal breaks each, tasks rather than patients were the priority, as the following vignette illustrates.

One night when the researcher was doing a night shift with third and first year students, they were about to begin the drug round when a high dependency patient was discovered to be doubly incontinent. If the researcher had not been available, the senior student would have been faced with the dilemma of prioritising task or patient. Since both

activities would have taken some time to complete, it is likely that the demands of giving the drugs punctually would have taken precedence over the temporary discomfort of the patient. One can only speculate, since on this occasion the student called on the researcher for assistance. Nurses were constantly faced with these difficult choices, particularly on the evening and night shifts.

As on the other study wards, first warders were supervised taking nursing histories and writing care plans, usually by third year students. The researcher was also asked for advice by first ward students on the principles of the nursing process as applied to record keeping and report writing using the kardex.

A third warder, who was on the ward for the two months prior to the period of participant observation, described the trained staff's attempts to make the kardex a more accurate reflection of patient care. Students were advised:

... not just (to) write 'had a quiet morning', 'had a bath' ... (but to) put things that were relevant, like 'been for a test', but if there wasn't anything to put then you weren't to put anything.

The student also appreciated having access to the communication book. She mentioned that trained staff would 'fill in the bits' during the lunchtime handover, including information from doctors' rounds. The same student also thought that it was very important that students reported on their allocated patients, as the trained staff 'didn't know what the patient was wanting or doing, because they are much more involved in the administration side'. The reporting system, therefore, provided students with 'a chance to put your opinions forward'. As mentioned above, however, more junior students did not always experience the ward handover reports in this way.

Patient-nurse allocation on Kinder ward was also fragmented, and students chose which patients they would care for. As on other wards,

first warders seemed more likely than other students to care for physically and emotionally dependent patients on a continuous basis.

6.3 Ward Learning Environment Questionnaires: Student Ratings on Ward Management Styles

In this section, the questionnaire findings are presented to provide additional evidence to findings obtained during interviews and participant observation. Tables 6.2 and 6.3 show section and item scores or ratings obtained for 12 medical wards. For consistency, all scores shown in the tables are presented in original rank order of the overall scores (chapter 5, table 5.19). Figures 6.1 and 6.2, which accompany the tables, demonstrate the significance of the findings at the 0.05 level when mean scores were compared between pairs of wards using Gabriel's test.

Firstly, findings obtained during interviews and participant observation suggested that the questionnaire scores relevant to describing sisters' ward management styles were derived from section B of the ward learning environment questionnaire. Students rated 'Ward Atmosphere/Staff Relations' by allotting a score of 5 to 1 on seven items. These items, which pertained to sister and trained nurses, were: Provide an atmosphere which is good to work in; Are concerned about what a student is thinking or feeling; Are available and approachable; Give reprimands in private; Praise and encourage the learner in her work; Work as a team with learners; Keep staff and learners well informed about ward activities. A mean score between 5 (most favourable) and 1 (least favourable) for section B was obtained from the sum of the individual item scores.

The scores obtained for item 2 which states 'I am happy with the experience I have had on this ward' are also presented. The decision to include item 2 in relation to ward management styles was based on findings from an analysis of interview data, that students associated

feelings of happiness with management styles that they perceived as positive.

It also emerged during interviews and participant observation that certain features of management styles could be perceived by students as 'causes' of stress/anxiety whilst working on a ward. Stress ratings for 12 medical wards were presented in chapter 5, table 5.27.

Secondly, relationships between scores obtained for section B and items 2 and 36 were tested using Pearson's correlation coefficient.

Finally, an analysis of responses to open-ended questions 37 and 41 on the questionnaire are presented in section 6.3.3 as additional evidence to support findings obtained from other methods of data collection.

6.3.1 Section and item scores

Table 6.2 shows the range of scores obtained for section B from students' ratings of 12 medical wards.

The ratings obtained by 12 medical wards for section B demonstrate a range of scores from 4.33 to 3.11 (table 6.2). The top three scores were achieved by wards (Windermere, Coniston, Langdale) which shared a reputation within the hospital for a heavy workload, generated by a high percentage of elderly female dependent patients. The score obtained by Windermere was significantly higher than those of all the other wards other than Coniston and Langdale. As discussed in chapter 5, the nature of the nursing work on these three highly rated wards made them less popular as perceived learning wards among students, despite the recognition that sisters and trained nurses created positive ward atmospheres and staff interrelationships. The score at the lowest end of the range (Loughrigg) was significantly lower than other wards, except for Ullswater.

Table 6.2

Students' ratings of 12 medical wards on Section B:
ward atmosphere/staff relations

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	3.93	.64
2. Eskdale	35	3.91	.71
3. Wastwater	34	3.81	.85
4. Ronda	43	3.99	.87
5. Edale	51	3.59	.80
6. Buttermere	35	3.70	.97
7. Ambleside	47	3.42	.96
8. Langdale	29	4.00	.68
9. Coniston	38	4.19	.62
10. Windermere	52	4.33	.58
11. Loughrigg	62	3.11	.87
12. Ullswater	50	3.21	.76

Figure 6.1

Gabriel's test of significance at the 0.05 level for comparison
between scores obtained on Section B

WARD NUMBER											
	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	N	N	N	N							
6	N	N	N	N	N						
7	S	S	S	S	N	N					
8	N	N	N	N	N	N	S				
9	N	N	N	N	S	N	S	N			
10	S	S	S	S	S	S	S	N	N		
11	S	S	S	S	S	S	S	S	S	S	
12	S	S	S	S	S	S	N	S	S	S	N

S = significant at the .05 level. N = not significant.

The ratings or scores for item 2, presented in table 6.3, showed a range of 4.32 to 3.60. Figure 6.2 demonstrates that these scores were not significantly different from each other, other than Loughrigg and Ullswater which were significantly lower than Kinder and Eskdale.

In relation to the stress/anxiety ratings obtained for the 12 wards, Windermere ward received the highest section B score but received the fourth highest stress/anxiety rating (table 5.27), which was significantly higher than 8 other wards using Gabriel's test. None of

the other wards (Edale, Buttermere, Wastwater) with significantly higher stress/anxiety ratings obtained section B scores that were significantly lower than the majority of other wards. The findings suggested that a positive management style alone was insufficient to override the students' stress created by the nature of the work and lack of trained staff.

Further explanations for the findings presented in tables 6.2 and 6.3 are sought through an analysis of comments made in response to open-ended questions 37 and 41 in section 6.3.2 below.

Table 6.3

Students' ratings of 12 medical wards on Item 2: 'I am happy with the experience I have had on this ward'

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	4.32	.66
2. Eskdale	35	4.23	.76
3. Wastwater	34	4.12	.80
4. Ronda	43	4.16	.80
5. Edale	51	3.82	1.01
6. Buttermere	35	3.80	1.19
7. Ambleside	47	3.98	.96
8. Langdale	29	3.97	1.03
9. Coniston	38	4.13	.95
10. Windermere	52	3.98	.89
11. Loughrigg	62	3.63	1.14
12. Ullswater	50	3.60	.96

Figure 6.2

Gabriel's test of significance at the 0.05 level for comparison between scores obtained on Item 2

WARD	NUMBER	1	2	3	4	5	6	7	8	9	10	11
2	N											
3	N	N										
4	N	N	N									
5	N	N	N	N								
6	N	N	N	N	N							
7	N	N	N	N	N	N						
8	N	N	N	N	N	N	N					
9	N	N	N	N	N	N	N	N				
10	N	N	N	N	N	N	N	N	N			
11	S	S	N	N	N	N	N	N	N	N	N	
12	S	N	N	N	N	N	N	N	N	N	N	N

6.3.2 Relationships between scores

A number of bivariate relationships between the variable ward management style, indicated by score B (Ward Atmosphere/Staff Relations) and the variables feeling of wellbeing, indicated by item score 2, and stress/anxiety, indicated by item score 36, were tested. Pearson's correlation coefficient was calculated for score B and each of the other variables (items 2, 36). Item score 2 and section score B were strongly positively correlated ($0.72, p < .01$), but there was no significant relationship between item score 36 and score B (-0.11).

The correlation coefficients confirm that sisters' management style contributed to students' feelings of wellbeing but did not alone contribute to students' stress/anxiety whilst working on a ward. Findings established in chapter 5, section 5.4.3, that stress/anxiety was multicausal, were supported.

6.3.3 Analysis of responses to open-ended questions

(a) Question 37: The main causes of stress or anxiety identified whilst working on this ward

As presented in chapter 5, section 5.4.5(c), a total of 106 comments were yielded from 79 questionnaires and 57 replies about the main causes of stress or anxiety whilst working on a ward. The comments were classified according to causes identified. 27 comments were associated with the ward sister and management styles. 28 comments were made about 'feelings' as a secondary cause of stress. 9 of these 28 comments suggested that the feelings were triggered by ward management styles as an underlying cause of stress. The causes of stress identified by respondents, other than those associated with ward management styles, are discussed in the relevant chapters above and below.

Each ward received at least one comment about ward management styles in the production of anxiety and stress. 5 of these comments were awarded to Ullswater, 4 to Loughrigg, and 3 to Ambleside. All three wards received ratings at the lower end of the range for section score

B (table 6.2). The scores for Loughrigg and Ullswater were significantly lower than the scores obtained by the other wards under study (figure 6.1).

In five other wards, the sister appeared to be the main cause of stress in 7 cases, 3 being on the same ward (Edale). 2 comments suggested that staff nurses rather than the sister were the main cause of anxiety or stress. Students also experienced anxiety or stress if they felt inadequately supported by trained staff (4 comments) or caught up in conflicts generated by hierarchical and/or personal relationships, including the way in which students' ward reports were handled (11 comments on six wards). Only 1 comment was made which associated poor relations between doctors and nurses as a cause of stress.

The following questionnaire comments described feelings as a secondary cause of stress that were triggered by ward management styles:

Confidence undermined, so that it became difficult to show initiative; made to feel inadequate if uncertain about care; on the defensive because of criticism.

As mentioned in section 6.2.2 above, one student on Windermere ward experienced stress triggered by feeling guilty at not doing her best because of difficulty in 'completing the workload' whilst 'giving maximum care and time to talk' to patients, in response to the sister's emphasis on communication.

On two oncology wards, although the students felt 'sad' or 'emotional' in addition to 'anxiety' generated by the nature of the work (chapter 5), they felt supported by the trained staff. On Buttermere ward, for example, one first warder felt that she could 'ask the staff any time'. As discussed in the ward case studies, students made similar observations about supportive and approachable trained staff on Windermere and Ronda. It may be inferred from these comments

about four wards that negative feelings associated with the nature of the work were made more tolerable by ward management styles which were supportive of students and which made trained staff accessible and approachable. In other words, these comments confirm that management styles either contributed to or alleviated feelings of stress/anxiety in students while working on the wards.

(b) Question 41: Other comments about the ward

Forty eight questionnaires yielded 70 comments in response to the question 'In case you have any other comments to make about the ward would you write them below'. As the potential number of questionnaire replies from the random sample was 79, 31 respondents did not make comments, although of those who did, some gave more than one comment.

29 of the 70 comments were associated with ward management styles. The comments supported those made in response to question 37 on causes of anxiety or stress and their association with ward management styles. However, they also provided insights into the nursing process as an indicator of ward management styles and the relationship of those styles to quality of nursing and the ward learning environment. The following comments are selected to illustrate the complex relationship among the variables. Comments on the study wards were considered in section 6.2 above. The comments made about other wards are discussed in the light of ratings for score B (Ward Atmosphere/Staff Relations). Wards were selected from across the range of ratings and the comments provide examples of students' different perceptions and interpretations of management styles.

Coniston ward (Section score B: 4.19)

The following comments demonstrate the differences between first and third year student perceptions of management styles. For example, two first year students were more positive about the management styles on Coniston ward than were third year students. The first year students

acknowledged that the sister and staff nurses were 'very friendly and approachable' and the 'atmosphere was relaxed and friendly'. Two third year students were less positive about the sister's management style: one because she felt that sometimes her ideas and observations were 'not listened to or taken into account', and the other because the ward sister, who was also a senior sister, was not, in her opinion, on the ward enough. The student concluded:

The staff suffer as no-one knows whether they are in charge or not.
Patients suffer as sister does not know exactly what is happening.
She only knows what she thinks is happening.

Eskdale ward (Section B score:3.91)

That students at similar stages of training could differ in their perceptions of ward management styles is illustrated by comments made by third year students. Their views of the management style on Eskdale ward differed, from considering there to be 'communication problems' between staff to stating that 'patient care was of a very high standard and "nurse care" was good and supportive on an emotional level'.

Buttermere ward (Section score B: 3.70)

The replies to question 41 about Buttermere ward again demonstrated the differences between first and third year students' perceptions of ward management styles. Two first year students shared views that the ward was 'a very friendly, easy introduction to nursing'. One student also recognised that 'high standards are set by sister on the ward'. However, a third year student experienced the ward as 'badly run' by a sister who 'didn't seem interested in the students'. Another third year student was more specific in her criticism in a comment which related to the handling of information as a feature of the way the sister interpreted the use of the nursing process. The student considered that rather than trained staff and students handling information about patient care separately, it would be more valuable and important for them to discuss patients and their future care plans together.

Ullswater ward (Section score B: 3.21)

Ullswater ward received the second to lowest rating on score B (Ward Atmosphere/Staff Relations). Both first and third year students were equally critical in their responses to question 41 (3 comments in all). On the one hand, a first warder found the third years 'very helpful and supportive. Although sister took little interest in staff, she appeared good at dealing with patient problems.' A third year student, on the other hand, commented that 'no efforts were made to make morale high'.

Loughrigg ward (Section score B:3.11)

There was only one response to question 41 that appeared in the sample and that was from a student in her third module. She merely commented that she 'would not have survived had it not been for third year students'. Loughrigg ward obtained the least favourable rating for score B (Ward Atmosphere/Staff Relations).

The comments made in response to question 41, presented above, illustrate that even when wards received favourable section B scores for ward atmosphere/staff relations, individual students identified less favourable features of management styles. A recurrent comment was one that identified shortcomings in the handling of information and feedback among students and trained staff. In the cases of Ullswater and Loughrigg wards where the students rated the trained staff's management styles at the lower end of the range of section B scores, first year students commented that third year students were their main source of support on the ward.

6.4 Summary of the Findings

The findings obtained using a multimethod approach to data collection are summarised below under conceptual categories related to working hypotheses about characteristics of ward management styles and the way in which sisters interpret the nursing process.

6.4.1 Ward management style and the creation of ward atmosphere and staff relations

The ward sister created the ward atmosphere and staff relations through her personal style of management. Staff nurses also contributed to the creation of the ward atmosphere and staff relations but the extent of their influence was dependent on the sister's management style.

Sisters and trained staff who were regarded by students as demonstrating favourable management styles were described as happy; approachable; interested in students as people; accessible both in physical and personal terms; giving positive feedback, which made students feel appreciated; were clear about what they expected from students as well as encouraging initiative; and allowed students to be involved in decision making and discussion about patient care.

Students valued ward sisters whose management styles involved giving direct patient care. In the students' view, such sisters were more likely to be familiar with the physical workload normally undertaken by students.

Students valued ward sisters who showed that they cared about patients by talking to them and their relatives and staying on duty longer than they should, to do this.

Management styles that created positive ward atmospheres and staff relations motivated students to care more for patients.

Some ward sisters created stress or anxiety for nurses through their management styles by being unappreciative and/or critical of students. However, management styles appeared to be only one component of stress or anxiety experienced by nurses during a ward allocation. Other ward sisters alleviated stress or anxiety by demonstrating a management style that was supportive and appreciative of students.

According to students, patients sensed an unhappy atmosphere and

unhappy nurses created by the sister and anxious staff nurses.

It would appear therefore that management styles experienced by students as favourable to learning and working were also favourable in terms of influencing the quality of nursing on a ward. These favourable management styles were also associated with sisters who recognised patients' and students' affective needs, undertook emotional labour themselves and encouraged others to do so.

The relationship between management styles and quality of nursing is elaborated further in chapter 7.

6.4.2 The nursing process as an indicator of ward management styles

Sisters who were approachable and accessible and demonstrated a 'caring' approach to patients and students, through recognising patients' affective needs and the need to do emotional labour, were more likely to interpret the nursing process as a way of involving students in decision making and discussion about patient care through a verbal and written reporting system that involved all grades of staff.

An explicit commitment to the practice of the nursing process appeared to be associated with sisters who valued interpersonal communication with patients and nurses, interpreted as the recognition of patients' affective needs and doing emotional labour.

Participant observation confirmed interview findings that ward sisters adapted the nursing process to their own work realities and work preferences.

Ward sisters identified the need to have contact with patients every day, but did not carry out an individualised nursing round in the way prescribed by Pembrey (1980). The sisters fulfilled stages of the management cycle in other ways, by allocating the work at the beginning of the shift, asking nurses to report on their work and also giving information about the patients themselves. However, the sisters varied in the amount of control they gave the nurses in exchanging verbal and

written information. Sisters made visible the patient care priorities valued on the ward by the way in which they controlled patient handovers and reports.

Students took nursing histories without supervision except in the first weeks of training. They viewed the nursing history as a task to perform rather than as part of a system of continuous patient allocation. There was no expectation that the person taking the history should follow it through with a care plan and giving of care to the patient even on the day of admission.

Care plans on two of the four study wards were not regularly updated. The two ward sisters who updated their care plans did so in different ways. On Windermere ward, the sister or trained staff updated the care plans in the context of the ward handover report. On Ronda ward, the sister updated the care plans periodically without consulting other staff. Findings obtained during interviews with students suggested that the nursing histories and care plans were not regularly updated in other wards.

Two ward sisters showed evidence of understanding the principles of individualised patient allocation by the way in which they allocated the work to accommodate changes in staffing levels and mix (Edale and Windermere wards). The sister on Ronda ward was never observed to allocate patients and nurses on a one to one basis, suggesting that she saw getting through the physical and technical labour as more important than doing emotional labour. The sister on Kinder ward prioritised certain tasks over others. These tasks, such as accurate recording of patients' fluid balance, were associated with the patients' medical condition.

Long term patient allocation was not practised, even on wards where sisters were committed to the the nursing process. Frequent change of patient was seen as desirable by more senior students in order to

satisfy their learning needs. Junior students were more likely to choose and/or be allocated to look after patients on a long term basis, especially if they required physical and emotional rather than technical labour. Some ward sisters and students, on the other hand, saw changing patients regularly as an important way of preventing overexposure of nurses to patients who might be 'difficult'. Consequently, students were observed to choose the amount of emotional labour they undertook, through a system of patient allocation that allowed them to change their patients daily.

Trained staff continued to carry out technical tasks, such as drug administration, superimposed upon patient allocation for students.

The sisters on the study wards said that they prioritised working with students, but direct contact between trained staff and students in caring for patients together was observed to be infrequent.

Junior and senior students usually worked together. Even when students were allocated groups of patients to care for in pairs rather than individually, they often divided the work between them. They organised their work in this way in order to complete it more quickly, with the result that they undertook patient centred tasks rather than patient centred care. Thus, although students were allocated groups of patients to care for during a shift, they rarely confined themselves to caring for their needs alone. Even junior students soon gave 'basic' patient care alone.

By the time students reached their third year they expected to supervise junior students, rather than be supervised themselves.

Students were quickly socialised often by other students into prioritising physical and technical labour, even on Windermere ward where patients' affective needs were made visible and emotional labour valued. Such priorities were not associated with acute medical and surgical nursing by most trained staff and students, except by students

in their first ward.

Following Menzies (1970), a possible explanation for fragmentation of care in this way was that nurses were protected from becoming too emotionally involved with individual patients, by continuing to undertake patient centred tasks rather than individualised patient care.

Smith (1986) referred to stresses associated with close nurse-patient relationships. She reported (like Rhys Hearn and Howard, 1980) that nurses maintained physical distance with patients, even when the ward was well staffed. Smith also found that long term staff-patient relationships were inhibited by limited staffing continuity and a ward culture which promoted busyness and consciousness of other staff's demands. Thus, the findings of the present study were supported by Smith's (1986).

In conclusion, the content of the care nurses gave was shaped by ward priorities, articulated through management styles and interpretation of the nursing process, staffing levels and their own work priorities.

The influence of management styles, use of the nursing process and the degree to which the recognition of patients' affective needs and emotional labour contribute to the quality of nursing on a ward is explored further in chapter 7.

CHAPTER 7

THE QUALITY OF NURSING

Introduction

This chapter describes, through the data, ways of conceptualising the quality of nursing. It was established in chapter 6 that the sister's management styles and interpretation of the nursing process influenced the ways in which she organised and prioritised care on her ward. Sisters also varied in the degree to which they recognised patients' affective needs and emotional labour as components of nursing.

It was confirmed in chapters 4 and 5 that students were the principal givers of direct patient care. It is hypothesised that their ability to give care is influenced by their learning and emotional needs at different stages of training. Findings presented in chapter 6 suggested that students were more likely to give a better quality of nursing in wards where the management styles of the trained staff ensured that their emotional needs were met.

The influence of management styles, use of the nursing process and the degree to which patients' affective needs and emotional labour were recognised on a ward are examined further in the light of the working hypothesis that patients judge quality of nursing by the emotional style in which it is given.

The findings for this chapter are derived from (a) interviews with patients; (b) field observations and student interviews from four study wards, including the results of direct observation on three of the wards using the Quality Patient Care Scale (QualPacs); and (c) self-administered questionnaires on students' attitudes towards the ward learning environment.

This chapter contains four parts. The first part presents patient

interview data in order to explore the sort of work patients expect nurses to do and the visibility of emotional labour as a component of nursing. In the second part, the results of the QualPacs' observations are presented from three of the study wards to illustrate indicators of quality of nursing, including the different priorities given and degrees of affective nursing and emotional labour undertaken on different wards. Additional data collected during observer participation and student interviews, are also presented. These data permit an exploration of quality of nursing and the emotional style in which it is given by students at different stages of their training. The cost of the associated emotional labour involved, and the interaction between particular ward environments and students in maintaining quality of nursing, are also described. Comparisons are made between the quality of data obtained using non-participant and participant observation.

The third part examines questionnaire findings on the ward learning environment, relevant to quality of nursing (score for section E: Patient Care) and its relationship with other variables, section score B (Ward atmosphere/Staff relations) item score 4 (The number of staff is adequate for the workload) and item score 6 (There are enough trained staff in relation to learners). The final part of the chapter summarises the findings obtained using the multimethod research approach.

7.1 Patient Interviews

The interview schedule and details of the interviewees have already been described in chapter 3. The patient interviews did not yield data that distinguished between differences in quality of nursing on the four study wards. Rather, the data yielded insights into patients' general perceptions of quality of nursing based not only on their current hospitalisation but also previous admissions both to City and other hospitals. No clear differences between observations made by men

(10 interviewees) and women (21 interviewees) were detected. The findings on quality of nursing are grouped around issues which address the working hypotheses identified early in the research. The interview data, therefore, were used to examine the working hypothesis that patients judge the quality of nursing by the emotional style in which it is given. The issues which address this hypothesis through the data are: (a) the sort of work patients expect nurses to do; (b) the visibility of emotional labour as a component of nursing; and (c) patient perceptions of the nursing process as indicated by patient-nurse allocation, ward routine and interpersonal communication.

The data also offer insight to the hypothesis that a student's ability to give care is influenced not only by learning and emotional needs at different stages of training, but also by ward management styles. The issues which address this hypothesis are: (a) perceived differences in the quality of nursing that students are able to give at different stages of training; (b) students' training needs; and (c) insights into ward atmospheres, routines and staff relations. Patients' perceptions of the City hospital as an institution, including their comments on the role of doctors in their care, are also considered.

During the interview, patients were asked to describe their idea of a 'good' nurse. The responses to this question illustrated (a) patients' expectations of nurses' work and (b) the visibility of emotional labour as a component of nursing.

A list of words and phrases was drawn up from patients' descriptions of their idea of a good nurse. The majority of these descriptions included characteristics associated with attitudes and feelings rather than technical competence.

Forty-four different words or phrases were used by the patients during interview, to describe both 'ideal' and 'real' nurses. Only six of these words or phrases referred to functional rather than affective

attributes. Coser (1962), who designed the original interview guide, reported similar findings. Words used to describe nurses' functional attributes included: 'efficient'; 'observant'; 'alert'; and 'capable of doing their job'. One patient combined both functional and affective attributes by expecting nurses to be 'caring but efficient'.

'Kindness, helpfulness, patience' were the affective attributes most frequently used to describe nurses in City hospital. Other words and phrases were used which showed a clear recognition by patients that nurses were expected to do emotional labour as defined by Hochschild (1983, p.7). For example, nurses were said 'to keep patients happy' by being cheerful, bright and maintaining 'buoyant good humour'. By being caring, loving, considerate, friendly and understanding, they would make patients feel 'they belong to you' or 'feel at home'. Talking, listening, showing interest and sympathy, all featured frequently as examples of the ideal nurse. One patient summed up what he valued in a nurse in the following way:

A nurse has to be aware of the patient's condition and how to tackle it. She has to have a nursing manner which requires a lot of patience and forethought and to try and relieve pain and suffering, not by medical means but by compassion. (Male patient, 53, Ronda ward)

A female patient who was a personnel officer appeared to recognise that nurses did emotional labour when she likened the necessity to be 'nice' as a nurse to a 'product'. She said 'In effect, you have to sell yourself in order to coax people'.

Another patient who was a trained operating theatre technician and wanted to train as a nurse also appeared to recognise nurses as emotional labourers, as illustrated in the following statement:

As a nurse, you are more at the beck and call of the public than in a supermarket. I tell the nurses 'Don't forget you're only human'. You see them when the patient keeps ringing the bell and they grimace to themselves. Then they go up to the patient, all smiles. (Male, 30, Ronda ward)

The high workload and dependent elderly patient population on

Windermere ward appeared to be reflected in the interviewees' frequent comments on the patience and kindness nurses showed towards 'the old people'. One patient remarked that the 'nurses didn't mind what they did' for them. A patient, herself elderly, thought the nurses were more important than the doctors and appreciated their care. The patients' comments on how they perceived the nurses' behaviour towards the elderly is in marked contrast to what nurses said and felt about caring for elderly people (see chapter 5). It may be inferred therefore that they (the nurses) were undertaking emotional labour to suppress the negative feelings they felt towards elderly patients.

Patients also described occasions to the researcher when they had seen students at the limits of their emotional resources but maintaining outward control. The patient on Windermere ward who was the personnel officer said:

These girls take it all. Sometimes they're a bit thin round the edges but they cope in the main.

The low staffing levels on night duty were referred to by a number of patients on all the study wards as being inadequate for the workload, so putting undue pressure on the students and trained nurses.

During participant observation on Kinder ward, for example, nurses and patients had been experiencing disturbed nights associated with three elderly confused patients. During the interview, a patient referred to a third year student who had been on night duty during this period in the following way:

That little nurse was almost at breaking point. She's an angel of mercy. I know I couldn't do it. It's hard to hold your temper. She did very well to cope and she was all white faced. (Female, 59, Kinder ward)

A female patient, 52, referred to the nurses on Windermere ward as 'angels', whereas another female patient, 47, on Kinder ward who was also a nurse challenged the image of the nurse as 'an angel of mercy'. 'Anyone can do it (nursing),' she said.

Associated with the image of the nurse as 'an angel' was also the belief by eight patients that nursing was a 'vocation' which required dedication. Two female patients viewed nursing as something 'you've got to have in you'.

Another patient articulated his idea of the 'good' nurse in the following way:

It rests so much in the girl how much she can give to the patient. It goes with that nature that brings them into this sort of vocation. (Male, 42, Ronda ward)

Yet another male patient reasoned that nursing must be a vocation since nurses 'wouldn't go in it for the money'.

The personnel officer who was a patient on Windermere ward was surprised during discussion with some students, when they told her that nursing was a 'job of work'. 'I'd always imagined it was a calling,' she said. The students' views expressed through the patient were consistent with both the views of the patient quoted above, who as a nurse objected to the 'angel of mercy' image, and the students referred to in chapter 4, section 4.3.2 (p.178).

Two patients described instances which suggest that they recognised when nurses withdrew emotional labour:

Nurses have got their work cut out (referring to the physical work load). They can only give you so much time. (Female, 72, Windermere ward)

If a nurse is abrupt with you, you go back a bit. (Female, 31, Kinder ward)

On the other hand another female patient, 53, who was a home help, described herself as 'too emotional' to do nursing. She gave the example of when clients died that:

... it's like losing one of your own. Some of the nurses must feel the same. In those cancer wards they must need to change, to prevent getting involved.

A male patient aged 34 on Edale ward, who liked nurses to be friendly and make him feel at home, also thought that 'care can be dangerous ... it's got to be platonic'.

A certain detachment and objectivity between nurses and patients, therefore, was seen as desirable.

The interviews also yielded data that confirmed findings presented in chapter 4, sections 4.3.1 and 4.3.2 (pp.176-186), on the selection and training of nurses at City hospital to do emotional labour, as illustrated by the following quotations:

Compared with other hospitals I've been in there's something special about City. In my independent view, it's because of the selection. The nurses are all on an even keel. They're of a similar type. They've always a smile, always got time for you and make you feel as if you're a person and not just passing through. (Female, 41, Personnel Officer, Windermere ward)

The nurse has got to know her 'nursing' but the training must be right. Then its her humanity immediately after that. (Female, 60, Kinder ward)

You need to train nurses to care for people and not to panic. (Female, 46, Windermere Ward)

The patient who was the personnel officer did not think that nurses could be taught how to communicate with patients. 'It's got to be there,' she said, 'although I think you can mould it'.

A male patient on Ronda ward in his forties expressed a similar view when he said:

You probably can't teach them to get it (communication). But you could advise them and if aspects of their personality will respond, you can teach them certain functions and give them hints and aids to guide them along those lines.

A 31 year old patient on Kinder ward thought that it was:

... part of the training to learn ... to put up with a lot when dealing with old people. They can be cantankerous, and the nurses need a lot of patience and to learn to hold it back.

Another young female patient (26 years old) who had been nursed in a Ronda side ward also thought that:

... a nurse must always try to be polite and nice and keep their bad feelings back. People when they are ill are much more susceptible, especially the elderly.

However, although this patient appeared to recognise the nurse's need to do emotional labour, she was also aware of the patient's

contribution to it, as the following quotation illustrates:

I tease and joke with them (the nurses). It's different and a great help. It's cheerful and I understand.

She added that she thought that being young was in her favour and allowed her to relate with the nurses in this way.

Male as well as female patients, on other wards and of different ages, also appeared to recognise that emotional labour was a two-way process between nurses and patients. A male patient, for example, commented that 'the nurses are nice, but that's a lot to do with the patients'.

A female patient on Kinder ward described being a 'good patient' as requiring 'give and take' between patients and nurses.

Eight patients identified either helping oneself or helping the nurses as characteristics of a good patient. In summary, the good patient did not complain or make demands on the nurse and was cheerful and smiled. Some patients appeared to hold similar expectations for doing emotional labour, both for themselves and nurses. On three of the four study wards, patients gave examples of other patients whom they regarded as 'bad' patients. All were described as 'demanding' by patient interviewees and one, who was also described as rude, was said to be creating a bad atmosphere on the ward. These findings support Kelly and May's (1982) definition through the literature of the 'good' and 'bad' patient.

The interviews also yielded data which offered patient perceptions of the nursing process as indicated by their views on patient-nurse allocation, ward routines and interpersonal communication.

As discussed in chapter 2, the nursing process is assumed to improve quality of nursing by personalising care through the allocation of individual nurses to individual patients and better interpersonal communication. Despite a commitment to patient allocation on the study wards, a consistent feature of the patient interviewees was that they

did not identify with any one nurse, as the following quotations illustrate.

The patient who was also a nurse, but had trained in the days prior to the introduction of the nursing process, said:

I don't know who's been allocated to me. The idea of one nurse whenever she's on duty looking after the same patient is a good idea in the ideal world ... but you (the nurse) have to go on holiday and often you're too busy to talk. It (the nursing process) could only work if you had two nurses working opposite each other. Anyway, the patient may get put off asking other people and it's better to allocate nurses to get to know the whole ward. (Female, 47, Kinder ward)

This patient's response reflected the views of students described in section 7.2 below. Not only was 'talking' seen as not part of being 'busy' but also exposure to a variety of patients rather than in depth relationships (implied by allocation to a few rather than all the patients on the ward) was seen as preferable in terms of learning needs. Another patient also observed that students needed to change patients and wards frequently in order to gain sufficient experience.

Patients regarded nurses collectively as a team with the sister at the head of it.

One elderly male patient on Edale ward said:

I never had to call the nurses. They were always calling on me; they served me great. (Male, 79, Edale ward)

That some nurses attempted to identify themselves with individual patients is illustrated in the following comment by a female patient on Kinder ward:

K introduced herself to me this morning (now mid-afternoon) and told me 'I'm looking after you today', and I haven't seen her again!

This patient, aged 60, was functionally independent and recovering from a cardiac catheterisation, compared with K's three other allocated patients who were all elderly and dependent for their basic needs. It appeared, therefore, that K had become so involved in their care that she had not maintained contact with her one relatively fit but

potentially anxious patient. This patient went on to say, however, that she was not complaining about K's 'disappearance':

I had very good service after that test. Sometimes my blood pressure had already been done when another nurse came to check it.

This comment suggested that nurses were still committed to 'tasks' (in this case recording a patient's blood pressure) rather than maintaining continuous care of their allocated patients.

Furthermore, the turnover of both students and patients on the ward militated against patient identification with individual nurses. For example, during the first months of the study (March-June 1984) the length of hospital stay in days by death/discharge, for the whole of City hospital, was as follows:

0-1 days ... 853 patients; 2-5 days ... 2246 patients;
6-9 days ... 924 patients; 10-14 days ... 718 patients.

Students at different stages of their training moved through the ward on average every eight weeks. This meant that on the ward at any one time there were up to five groups of students at different stages of training. Every three weeks at least one student from one of these groups began a new ward allocation, whilst another one left. It was not surprising therefore that when patients did identify with individual nurses it was usually with senior staff nurses or the ward sister.

A patient who had been in the hospital for three weeks thought that she got to know the nurses 'nicely' in that time because she saw them on both night and day duty, in a way that was not possible during a shorter stay. She concluded that during a three week stay 'you see quite a lot of them'.

The data also illustrated interesting insights about interpersonal communication between doctors, nurses and patients. Patients did not see the nurses, even the sister, as independent agents. The content of their work, including information-giving, was perceived as being shaped by the medical profession. One patient on Kinder ward, aged 60, gave a

majority view:

Doctors and nurses have two distinct types of work. The doctor tells you what's wrong and decides what's to be done. Nurses carry out all the orders. Sister is in between and can make decisions that even staff nurse can't make, like in an emergency on a heart ward like this.

Most patients said that they thought the doctor rather than the nurse was the person who should and could give them information about their condition.

Some comments on specific aspects of communication between nurses and patients point to its importance as a component of nursing, despite the perceived dominance of the doctor in information-giving. However, not all nurses were equally able to satisfy the patient's need for information, as the following quotations suggest:

There are some nurses I'd rather ask than others ... You can tell that they are more experienced in their job and can tell you ... I prefer a nurse who's done two or three years, or staff nurse. (Female, 66, Kinder ward)

Another patient aged 60 and also on Kinder ward said:

A good nurse has to guess how much a patient wants to know. Me, for example, I'd stop them telling me too much, but other patients might not.

A male patient, 47, on Ronda ward said:

Nurses are more involved with a smaller number of people than the doctors ... they take an interest in how people are getting on and sort out their little problems.

One female patient, 78, on Windermere ward, saw the workload as intrusive:

Nurses are so rushed in the mornings and they get called away in the middle of conversations.

This comment suggested that the major part of the physical workload was undertaken in the morning, rather than spreading out the work over the day. Non-participant observation, described in section 7.2.1 below, confirmed this finding.

However, comments from other patients implied that the aim of the nursing process to break down ward routine might not be wholly what

they wanted nor saw as realistic. The personnel officer on Windermere ward, who had had multiple hospital admissions, said:

A little bit of me is sorry that the emphasis on routine has gone. It keeps the ward on its toes.

Another patient when asked what makes a ward good for patients said:

A sister who controls the ward ... all orderly and no panic and everything kept neat and tidy. (Female, 72, Windermere ward)

Yet another female patient, aged 66, said that routine was important for patients, 'Otherwise they don't know whether they're coming or going'.

As discussed above, some patients described nurses' ability to do emotional labour not only in terms of particular personality types and selection procedures but also formal and/or informal learning processes. As the data on interpersonal communication suggests, they were also aware of differences in levels of competence at different stages of training and between students and trained staff. This awareness of differences between different grades of staff was also apparent to patients, not only in terms of seeking information, as described above, but also technical abilities, as the following quotations suggest. The indicator of seniority which the patients referred to was an air of confidence and authority which was judged to increase as nurses became more senior.

Male patients, Ronda ward, aged 47 and 66 respectively:

You can sense who are the third years. They are more confident than the first years.

You can't distinguish between the years by uniform, but the staff nurse has an air of authority.

And female patients:

Staff nurse has more authority. By the second year, they get more confidence as they go on. (Aged 72, Windermere ward)

You can see the differences between second and first years and the staff nurse. She (staff nurse) appears much more confident to me. She's more at ease, she knows what she's doing and she has an ease at her job. (Aged 44, Kinder ward)

You can tell the new nurses. They are watching as if they don't know what to do next. (Aged 58, Windermere ward)

As they go on, they get more confidence and authority. For example, a first year taking a blood pressure doesn't do it with the same confidence. They take longer. (Aged 60, Kinder ward)

This last patient recounted the experiences she had had in a Midlands hospital where her husband had been admitted for treatment of cancer, from which he subsequently died. She described the nursing organisation, in the ward where her husband had died, as 'tiered'. This system meant that nurses carried out more sophisticated tasks according to their seniority. Thus the more 'menial' tasks, such as giving out urinals, were carried out by the most junior staff. If the appropriate staff were not free to carry out a task when a request was made, then the patient might be kept waiting until they were available. The patient described a situation which had caused both herself and her husband much distress when he had been kept waiting for a urinal for over an hour. The experience led the patient to conclude:

You can't expect the juniors to do everything. Where necessary, the seniors can help with the more menial side of nursing. Juniors need to be supervised.

Two other female patients specifically valued ward sisters who undertook so-called 'menial' tasks. On Windermere ward a patient, 79, said of the sister: 'Sister is wonderful. She gave me a bed bath.'

On Kinder ward another patient, 71, expressed her approval that the sister would do anything for the patients, including responding to patient requests to use the commode.

On Ronda ward a patient, 30, expressed approval that the sister came and worked on the ward whereas another patient, 53, thought that 'menial' activities should be given to auxiliary nurses as they were in his local hospital, reserving the more 'important' technical duties for the qualified staff.

Two female patients noted that nursing was becoming more technical

and referred to computerisation as an indicator of this.

In terms of students' training needs, patients observed that more experienced nurses taught the more junior staff. They did not distinguish however whether the juniors were taught by trained staff or more senior students. Patients described teaching/learning activities in the following way:

The nurses are just like a family. The older ones teach the younger ones. (Male patient, 57, Edale ward)

You notice the different grades of staff on their first day in the ward when you hear the other nurses talking them through it. (Female patient, 60, Kinder ward)

Another patient assumed that some of the nurses were still in training because they asked other nurses what to do.

Overall, the patient interview data confirmed that patients recognised that nurses had different levels of competence at different stages of training and that they relied on more senior nurses (who were not necessarily qualified) for their learning.

Patient perspectives on styles of management and quality of nursing and learning were minimal, but the following insights were gained from a number of interviews.

Patients frequently commented on the friendly and relaxed atmosphere of the study wards. Patients on Windermere and Kinder thought that the atmosphere of the ward depended on the sister. One patient aged 66 on Windermere compared present day ward sisters with those she had known in the past. She said:

Ward sisters are mostly nice these days; perhaps they've softened. They get to know people more, rather than being superior as in the past.

Another patient, 72, on Windermere ward, said:

If staff work well with sister then the atmosphere of the ward is well. They shouldn't be frightened of her.

The link between the sister's management style in relation to nurses and patients was made by a patient who commented:

Sister is very easy (on this ward) which may make nurses easier towards the patients. (Female, 58, Windermere ward)

Some patients made oblique comments about the lack of 'coloured' nurses in the City hospital which they compared with other hospitals where they had previously been admitted. They appeared to view the nurse population more positively in terms of the quality of nursing they received at City hospital. Although the researcher did not explore the issue of patients' implicit racist attitudes towards nurses further during the interviews it might be hypothesised that, because the majority of patients admitted to City hospital were white, they preferred to be nursed by white nurses. Hence, one indicator that patients might use to judge quality of nursing was the homogeneity of the staff in relation to their own background.

Finally, during the interview, patients described their hospitalisation not only in terms of their ward experiences but also in terms of being admitted to City hospital in particular. Many patients had been referred from their local hospitals outside Central London and made comparisons between their experiences of each.

The quality of hospital care was judged not only in terms of nursing but also the technical expertise of the medical staff and the friendliness of all other categories of staff. One patient, 72, on Windermere ward, said:

This is a really lovely hospital, right through - even in out-patients ... they are very kind to you.

Another said:

The nurses, doctors and domestics - they all make you feel at home. (Female, 53, Kinder ward)

Yet another:

Some doctors talk down to you, but not in this hospital. (Female, 60, Kinder ward)

And another:

Some hospitals you ask questions and get passed off. But here it's different. Nothing is too much trouble. (Male, 30, Ronda ward)

Two patients understandably thought that City was 'a wonderful hospital' since one had been resuscitated following a cardiac arrest and another had been successfully treated for severe haemorrhage from a duodenal ulcer.

Two patients said that they preferred to be admitted to the City hospital rather than any other, even if they died on the way there. One patient even carried a card in her handbag asking to be taken to the City hospital in case of accident or sudden illness.

One patient summed up the reasons for patients' favourable views of City hospital:

The teaching hospital comes out on top. They've got the specialists. No matter what you come here with, you always seem to come out of it. I've got faith in the consultant and the nurses.

Cornwell (1984) also found in an enquiry into people's ideas about health, illness and the health service that they preferred to be treated in teaching hospitals. The reasons for their preferences, according to Cornwell, were that they believed, like the City hospital patients, the staff were better trained and the hospitals better equipped than in non-teaching and/or smaller hospitals. The patients in the present study also believed that the staff of the City hospital were more friendly and kind than the staff in their local hospitals.

7.2 The Quality of Nursing on Four Study Wards

7.2.1 The quality of nursing as measured by the Quality Patient Care Scale (QualPacs)

As described in chapter 3, the QualPacs scale was used on three of the four study wards, i.e. Windermere, Ronda and Kinder. Each non-participant observation period (three sessions on each ward) yielded the following data, presented in tables 7.1-7.7.

Tables 7.1-7.3 show the provision of the structure for care in terms of the total number of patients, their dependency and the staffing

levels on each ward during the 24 hours and shift in which each observation session took place. The mix of trained staff, senior and junior students, and the ratio of trained staff to learners, is also given for each shift.

Tables 7.4-7.6 present information on the number of patients being observed during each session, the number and range of interactions received by them in a two-hour period and the number of nursing hours required by them as a group in the 24 hours during which the observation took place. Ratios were calculated for the proportion of nursing hours required in relation to the requirements of the total patient population in 24 hours. The number and grade of staff involved in each nurse-patient interaction, and the way in which the nursing work was allocated and organised for the patients under observation, is also shown.

These data are used to demonstrate patterns of nurse-patient interaction in terms of the number of interactions undertaken by allocated and other nurses for each patient under observation during three two-hour observation sessions, and as indicators of the way in which the nursing process was interpreted on each of three study wards. Ratios were calculated for the proportion of patient interactions carried out by allocated nurses in relation to the total number of patient-nurse interactions (including those interactions undertaken by non-allocated nurses) per total number of patients observed on each of three wards during three sessions.

Table 7.7 shows the scores obtained using the QualPacs scale. The scores represent the quality of nursing as measured by the QualPacs scale during three observation sessions on each ward.

The proportion of psychosocial care was expressed as a ratio of all dimensions of care in order to assess the extent to which staff recognised patients' affective needs and did emotional labour during

non-participant observation on three wards. Ratios were calculated from the sum of psychosocial item mean scores as a proportion of the sum of item mean scores for six dimensions of the scale, for three observation sessions on each ward. A one way analysis of variance was used to test whether the differences in scores were significant at the 0.05 level.

Table 7.1

The structure for care: workload, staffing levels and mix for both the 24 hour period and the shift in which the QualPacs observation sessions took place: Windermere ward

	SHIFT, WEEK OF STUDY		
	WEEK 8 MORNING	WEEK 2 AFTERNOON	WEEK 6 EVENING
Total number of patients	20	19	19
Total patient hours required in 24 hours	84.6	96.0	84.0
Total number of nurses	13	17	11
Nursing hours available in 24 hours	70.0	122.5	83.75
Number of nurses on shift	6	10	4
Total nursing hours by shift	28.5	29.4	18.0
Nursing available per hour	5.7	8.4	3.6
<u>Staffing levels and mix during shift</u>			
Sister	0	1	1
Staff nurse	1	2	0
3rd year student	2	2	1
2nd year student	1	0	0
1st year student	0	3	2
'Team'	2	2	0
Total trained staff	1	3	1
Total students	5	7	3
Proportion of trained staff	0.17	0.30	0.25

Note: See chapter 5, table 5.5, for explanation of duration of a shift and formula for working out number of nursing hours available per hour on a shift.

Table 7.2

The structure for care: workload, staffing levels and mix for both the 24 hour period and the shift in which the QualPacs observation sessions took place: Ronda ward

	SHIFT, WEEK OF STUDY		
	WEEK 2 MORNING	WEEK 6 AFTERNOON	WEEK 8 EVENING
Total number of patients	23	22	22
Total patient hours required in 24 hours	79.3	66.0	61.3
Total number of nurses	13	11	11
Nursing hours available in 24 hours	95.25	83.75	83.75
Number of nurses on shift	6	7	4
Total nursing hours by shift	28.5	20.75	18.0
Nursing available per hour	5.7	5.8	3.6
<u>Staffing levels and mix during shift</u>			
Sister	0	0	1
Staff nurse	3	2	0
3rd year student	1	3	2
2nd year student	0	0	1
1st year student	2	2	0
'Team'	0	0	0
Total trained staff	3	2	1
Total students	3	5	3
Proportion of trained staff	0.50	0.29	0.25

Table 7.3

The structure for care: workload, staffing levels and mix for both the 24 hour period and the shift in which the QualPacs observation sessions took place: Kinder ward

	SHIFT, WEEK OF STUDY		
	WEEK 8 MORNING	WEEK 6 AFTERNOON	WEEK 3 EVENING
Total number of patients	15	14	14
Total patient hours required in 24 hours	57.3	58.0	66.0
Total number of nurses	11	9	11
Nursing hours available in 24 hours	86.5	71.5	83.75
Number of nurses on shift	6	7	4
Total nursing hours by shift	28.5	20.25	18.0
Nursing available per hour	5.7	5.8	3.6
<u>Staffing levels and mix during shift</u>			
Sister	1	0	1
Staff nurse	1	2	0
3rd year student	2	4	2
2nd year student	2	0	0
1st year student	0	1	1
'Team'	0	0	0
Total trained staff	2	2	1
Total students	4	5	3
Proportion of trained staff	0.33	0.29	0.25

Table 7.1 illustrates that on Windermere the workload was consistently higher for the 24 hours during which the observation took place than on either Ronda (table 7.2) or Kinder (table 7.3). The tables also show that, with the exception of the afternoon shift on Windermere, the total nurse hours available per hour and per shift in the morning and evening were the same on all three wards irrespective of workload. In looking at the staffing data for the observation sessions for all three wards, Windermere was the only ward to have 'team' nurses on duty. Since 'team' nurses were sent on a daily basis to wards where the

staffing levels were low and/or workload was high and were often allocated to a different ward daily, it could be inferred that their familiarity with and contribution to the ward was likely to limit the quality of nursing they were able to give. The average ratio of trained staff to students (range of 0.17 to 0.50) was lower overall on Windermere than on either Ronda or Kinder. On all three wards, the third year students appeared to be the mainstay of the service in terms of numbers on duty during the observation sessions and observed interactions with patients. These findings confirm those presented in the ward profiles in chapter 5, section 5.3 (p.246).

Taking the three wards as a whole, tables 7.4-7.6 show that the number of nurse-patient interactions per patient during the observation sessions ranged from 1 to 12 interactions. The minimum range varied from between 1 and 5 per patient and the maximum range of interactions varied from between 5 and 12 per patient. These ranges suggest that patient-nurse interaction varied and that some patients only interacted once with a nurse in a two hour period. Reasons for the variability in patient-nurse interaction appeared to be partly influenced by the patient's level of dependency, as the following findings suggest.

These findings are based on an analysis of QualPacs observation schedules and fieldnotes. For example, on Windermere ward two patients received only 1 interaction each because they were physically independent as defined by the Barr (1967) dependency checklist. On the other hand, one dependent patient received 1 interaction of 45 minutes duration, during the morning observation session. The interaction involved bed bath, pressure area care and oral hygiene, during which the student was interrupted seven times. The interruptions were from other patients requiring commodes, other nurses requiring help with lifting their allocated patients, and requests from the student herself for help to turn and position her own allocated patient.

Table 7.4

QualPacs observation sessions: patient characteristics, nurse-patient interactions and nurse allocation: Windermere ward

	SHIFT, WEEK OF STUDY		
	WEEK 8 MORNING	WEEK 2 AFTERNOON	WEEK 6 EVENING
Number of patients observed	4	5	4
Hours of nursing in 24 hours	20	13.33	16
Proportion of total nursing hours required	0.24	0.14	0.24
Total number of patient-nurse interactions	15	25	19
Range of number of interactions per patient	1 - 6	1 - 10	1 - 9
<u>Interactions with:</u>			
Trained nurse	4	4	4
3rd year student	8	8	4
1st year student	0	8	8
<u>two or more nurses:</u>			
Trained	0	0	0
Trained student	1	2	2
Student	2	2	1
Allocated nurse(s) present	9	20	11
Proportion of interactions with allocated nurse	0.60	0.80	0.58
Designated allocation*	M14 & M15 (4)	M14 & M1 (5)	M14 & M1 (2) M3 (2)

* Designated allocation code:

M - module of training

1, 3 - 1st year student

5 - 2nd year student

12, 14, 15 - 3rd year student

S/N - staff nurse

SR - sister

Number in brackets - number of allocated patients.

Table 7.5

QualPacs observation sessions: patient characteristics, nurse-patient interactions and nurse allocation: Ronda ward

	SHIFT, WEEK OF STUDY		
	WEEK 2 MORNING	WEEK 6 AFTERNOON	WEEK 8 EVENING
Number of patients observed	5	5	5
Hours of nursing in 24 hours	13.33	16.66	20
Proportion of total nursing hours required	0.17	0.25	0.33
Total number of patient-nurse interactions	17	22	21
Range of number of interactions per patient	2 - 5	1 - 12	2 - 7
<u>Interactions with:</u>			
Trained nurse	7	6	4
3rd year student	0	9	9
1st year student	6	4	0
<u>two or more nurses:</u>			
Trained	2	0	0
Trained student	0	2	5
Student	2	1	2
Allocated nurse(s) present	14	14	16
Proportion of interactions with allocated nurse	0.82	0.64	0.76
Designated allocation*	M14 & M1 (2) M3 & S/N (3)	M12 (am) (2) M15 & S/N (am) (3) M1 & S/N (pm) M1 & M5	SR & M5 (2) M15 & M5 (3)

* Designated allocation code:

M - module of training

1, 3 - 1st year student

5 - 2nd year student

12, 14, 15 - 3rd year student

S/N - staff nurse

SR - sister

Number in brackets - number of allocated patients

Table 7.6

QualPacs observation sessions: patient characteristics, nurse-patient interactions and nurse allocation: Kinder ward

	SHIFT, WEEK OF STUDY		
	WEEK 8 MORNING	WEEK 6 AFTERNOON	WEEK 3 EVENING
Number of patients observed	4	3	4
Hours of nursing in 24 hours	24	20	16
Proportion of total nursing hours required	0.42	0.34	0.24
Total number of patient-nurse interactions	24	21	20
Range of number of interactions per patient	3 - 10	5 - 10	2 - 9
<u>Interactions with:</u>			
Trained nurse	3	6	2
3rd year student	10	2	9
1st year student	4	6	5
<u>two or more nurses:</u>			
Trained	0	0	0
Trained student	0	5	0
Student	7	2	4
Allocated nurse(s) present	12	14	13
Proportion of interactions with allocated nurse	0.50	0.66	0.65
Designated allocation*	M5 (2) M5 & M15 (2)	M15 (3)	M15 (2) M1 & M12 (2)

* Designated allocation code:

M = module of training

1, 3 = 1st year student

5 = 2nd year student

12, 14, 15 = 3rd year student

S/N = staff nurse

SR = sister

Number in brackets = number of allocated patients.

On Kinder ward, the minimum number of interactions ranged from between 2 and 5. The reasons for the higher range of minimum interactions than on the other two wards appeared to be associated with the dependency of the patients being observed. Four of the total number

of patients being observed for all sessions on Kinder ward regularly initiated interactions with the nurses. The two groups of patients during the morning and afternoon sessions generated a high workload, requiring frequent nursing interventions including supervision of intravenous therapy and nasogastric feeding.

The patient receiving the highest number of interactions on Ronda ward (i.e. 12) was an elderly man who was recovering from an acute confusional state precipitated by liver failure. In his confusion he kept walking off the ward and had to be chaperoned whenever possible, to prevent this. He also needed help to operate the portable ward telephone.

The general impression from all the observation sessions on the three wards was that nurse-patient interaction was predominantly initiated by nurses rather than patients. In terms of the number of interactions undertaken by allocated nurses for each patient under observation, expressed as a ratio of total interactions, ranging from 0.50 to 0.82, the following inferences were drawn from the data presented in tables 7.4-7.6. The highest proportion of interactions with allocated nurses took place on Ronda, and the lowest proportion occurred on Kinder. Windermere ward was in between. These ratios were compared with data obtained during the handover between shifts when the nurse in charge organised the nursing work by allocating groups of patients to nurses to work either individually or in pairs.

On Ronda during the sessions observed, nurses were more likely to work in pairs than on Kinder. During the afternoon observation session on Ronda, patients had two sets of allocated nurses overlapping from two shifts. The overlap of staff in this way was not observed on Windermere and Kinder during the QualPacs observation sessions. This finding might explain why, on Ronda, a higher proportion of interactions took place between patients and allocated nurses than on

Windermere or Kinder. On Windermere, the proportion of interactions with allocated nurses was reduced on the evening shift, which appeared to be explained by the way the work had been allocated: i.e. two patients had been allocated to individual, rather than a pair of, nurses. In this way, if patients only had one allocated nurse, it appeared that their interaction with nurses who were specifically allocated to care for them decreased in relation to the number of interactions with non-allocated nurses. On the other hand, if two nurses were allocated to care for a group of patients, then the likelihood of interacting with allocated rather than other nurses increased.

These findings demonstrate that a system of patient allocation of groups of patients to one nurse rather than pairs of nurses, prescribed by the nursing process, was not consistently in operation on the study wards during the observation sessions. Furthermore, the nurses appeared to organise their work around traditional work routines in which the majority of the physical work was undertaken during the morning. Consequently the number of interactions between nurses and patients varied. The variability appeared to depend to some extent on the physical dependency of the patient (as described above) and the tendency of the majority of nurses to put higher priority on getting through the physical workload and routine tasks such as drug rounds, before meeting patients' affective needs and doing emotional labour. These findings are supported by data obtained during participant observation and presented in chapter 6, section 6.2.

In looking at tables 7.4-7.6, in which data are presented for the number of interactions with patients which involved two or more nurses, Ronda is the only ward where two trained nurses together interacted with one patient. Kinder ward illustrated particularly high numbers of interactions involving two or more students, suggesting that either nurses were more likely to work in pairs, despite nominal allocation of

one nurse to a group of patients, or that high patient dependency required the allocated nurse to seek help from other nurses. Data presented in chapter 6, sections 6.2.1(c)-6.2.4(c), would support the former interpretation.

The contact between trained nurses and students in giving care to patients together appeared to be less than students giving care either by themselves or with other students. As noted above, the third year students were the mainstay of the nursing service in giving direct patient care.

Table 7.7, the quality of care scores as measured by Qualpacs, shows that on all three wards favourable scores were achieved on the QualPacs scale, in the range of between 'best' and 'average' care (4.7 to 3.6).

Table 7.7

Qualpacs observation sessions: mean scores by QualPacs dimensions 1-2 (psychosocial) and 1-6 (overall) quality of care scores

TIME OF SESSION	QUALPACS SCORES BY DIMENSIONS		PROPORTION* OF PSYCHOSOCIAL CARE (DIMENSIONS 1-2)
	1-2	1-6	
<hr/>			
<u>Windermere</u>			
Morning	4.3	4.6	0.26
Afternoon	4.4	4.5	0.35
Evening	3.8	4.1	0.24
Mean	4.2	4.4	0.29
<hr/>			
<u>Ronda</u>			
Morning	4.2	4.0	0.28
Afternoon	4.5	3.8	0.44
Evening	4.8	4.7	0.28
Mean	4.5	4.2	0.33
<hr/>			
<u>Kinder</u>			
Morning	4.3	4.5	0.26
Afternoon	3.9	4.3	0.25
Evening	4.1	3.6	0.35
Mean	4.1	4.2	0.28

* See p.404 for explanation of calculation.

The differences in scores were not significant, using a one-way analysis of variance. As discussed above, the recognition of patients' affective needs and the prioritisation of emotional labour on each ward was sought through an analysis of the psychosocial dimension scores 1 and 2 on the QualPacs scale and the proportion of care that was psychosocial in relation to overall care. The proportion of psychosocial care was expressed as a ratio of the sum of item means for dimensions 1 and 2, and the sum of item means for all six dimensions of care. All three wards achieved favourable scores on the psychosocial dimensions of care, in the range of between 'best' and 'average' care (4.8 to 3.8). The range of psychosocial scores which were not significantly different from each other, using a one way analysis of variance, was slightly higher than the overall scores.

The findings presented in table 7.7 suggest the following: On all three wards, psychosocial care, although of a high quality as measured by QualPacs, appeared to constitute a lower proportion of care work (0.24 to 0.44) than the combined contribution of other aspects of care measured on the QualPacs scale. Windermere and Kinder wards achieved similar ratios and average scores on dimensions 1 and 2 of the scale, whereas Ronda had a higher ratio and average score. This finding was not consistent with those presented in chapters 5 and 6, which suggested that Sister Windermere was much more orientated to patient-nurse communication and interpersonal skills than the sisters on Ronda and Kinder. This orientation was not reflected in the QualPacs scores and ratios.

Tables 7.1-7.3 show that, in terms of the structure for care on Windermere, although the workload was higher, the staffing levels and mix were not dissimilar to the staffing levels and mix on Ronda and Kinder. However, the quality of psychosocial and overall care as measured by QualPacs was still maintained at a similar level on all

three wards. It is possible that nurses on Windermere ward worked hard to maintain quality of nursing irrespective of the heavy physical workload, but that the proportion of psychosocial to overall care decreased, despite the sister's commitment to patient-nurse communication. Neither was the absence of the sister's explicit commitment to meeting patients' affective needs and doing emotional labour, on Ronda, sufficient to prevent individual nurses undertaking higher proportions of psychosocial care during one observation session than on other wards.

Even though the differences in the aggregated QualPacs scores were not significant, it was decided to examine each observation session on the three wards, in order to see if the scores accurately reflected variations in the ward environment which affected the quality of nursing. The sessions are analysed in terms of the ward context in which the observation took place and the patients and nurses being observed during each session.

Windermere ward (Tables 7.1, 7.3, 7.7)

Morning observation session

The highest overall QualPacs score (4.6, table 7.7) on Windermere was achieved during the morning observation session. This occurred even though the ratio of trained staff to students was at its lowest for the three observation sessions but no first year students were on duty. Neither did the presence of 'team' nurses appear to affect the overall score. Both 'team' nurses were senior third year students awaiting state final results.

The four patients under observation during the morning session on Windermere represented a ratio of 0.24 of the total workload (tables 7.1 and 7.4). The care they required, therefore, was representative of the overall workload on the ward in 24 hours. All care was given by either trained staff or senior students, which may have accounted for

the maintenance of quality despite the comparatively high workload and low trained staff/student ratios.

Afternoon observation session

Both staffing levels and the ratio of trained staff to students were the highest during the afternoon observation session, compared with all other sessions on all wards (table 7.1). The QualPacs score of 4.6 (table 7.7) was not the highest obtained during observation, suggesting that greater numbers of staff will not necessarily ensure higher quality of care. The psychosocial care scores (4.4) were the highest of the three sessions for the ward. These data suggest that when staffing levels were favourable, patients' affective needs and emotional labour were able to be prioritised, despite the highest workload of any ward for the 24 hour period during which the QualPacs observation took place.

The patients under observation were not representative of the heavy workload on Windermere that day, representing a ratio of only 0.14 of the total nursing hours required in 24 hours (tables 7.1 and 7.4). Care was given to those patients by all grades of staff, including junior students. It might appear, therefore, that favourable staffing ratios and low workload created the conditions for patients' affective needs to be prioritised and emotional labour to be undertaken.

Evening session

The score for the evening session (3.8, table 7.7) was the lowest achieved of the three sessions on Windermere. The psychosocial score was also the lowest for all sessions and for all wards during QualPacs observation. Although the ratio of trained to student nurses was not the lowest for the three sessions on Windermere ward, the actual number of first year students in relation to more senior staff on duty was higher (table 7.1).

The four patients under observation represented a ratio of 0.24 as a

proportion of the total workload in 24 hours (tables 7.1, 7.4). They were therefore representative of the overall workload on the ward. Nearly 50% of all interactions were undertaken by first year students alone (table 7.4), suggesting that the lower scores reflected the inexperience of the staff on duty.

Ronda ward (Tables 7.2, 7.5, 7.7)

The morning session

The workload for the 24 hours in which the morning observation session took place on Ronda was at its highest for the three sessions observed on the ward (table 7.2). However, staff hours available appeared to be well in excess of patient hours of care required. Staffing ratios of trained staff to students were at their highest on Ronda for all three sessions. QualPacs scores were at the lower end of the range at 4.0 (table 7.7). The psychosocial score, however, was slightly higher than the overall score at 4.2.

The patients observed represented a ratio of 0.17 of the total workload in 24 hours (table 7.2, 7.5). Approximately 50% of the interactions were carried out by first year students and the other 50% by trained staff. It may be inferred that the quality of nursing as indicated by QualPacs scores (table 7.7) remained at the lower end of the range of scores because of the relative inexperience of the students giving 50% of the direct care. However, the quality of psychosocial care appeared to be slightly higher than the overall care score, which might have been favourably influenced on the one hand by the high percentage of interactions with trained staff as well as students and the relatively low workload generated by the patients being observed. The ratio of psychosocial to overall care remained in the middle range, at 0.28, perhaps because the trained staff in particular were also involved in managing the comparatively high workload generated by the other patients on the ward.

Afternoon session

The lowest of the three QualPacs scores (3.8, table 7.7) obtained during observation on Ronda was achieved during the afternoon observation session. Staffing levels were seemingly favourable for the workload during the 24 hour period during which the observation took place (table 7.2). The psychosocial care score was considerably higher at 4.5, and the proportion of psychosocial care to overall care was the highest ratio achieved for any session on any of the three wards (table 7.7).

The patients observed during the session represented a ratio of 0.25 of the total workload in 24 hours (tables 7.2, 7.5). Only 18% of the interactions were carried out by first year students alone, the remainder being by trained staff and senior students.

The high psychosocial care score and ratio of psychosocial to overall care (0.44, table 7.7) was favourably influenced by interactions between two patients and a staff nurse from the geriatric day hospital. This staff nurse was on Ronda ward for a short period after accompanying a patient back from the day hospital to the ward. She was not, therefore, a member of the ward staff, but the high quality and quantity of her interaction with two patients, in terms of individual and group psychosocial care, both produced a high QualPacs score for these dimensions as well as increasing the proportion of care that was psychosocial with the patients under observation.

These findings suggest that individual nurses' abilities and preferences to respond to patients' affective needs by doing emotional labour influence the QualPacs scores independently of ward variables such as staffing levels and the sister's work preferences.

Evening session

The score (4.7, table 7.7) for the evening observation session on Ronda was the highest for any session on all three wards. The workload

for the 24 hour period was the lowest of the three days during which observation took place, and staffing levels appeared to be favourable (table 7.2). The psychosocial care score (4.8) was not only higher than the overall care score but represented the highest score achieved for dimensions 1 and 2 on the QualPacs scale than on any other ward or during any other session. The proportion of psychosocial care, however, remained in the middle range, with a ratio of 0.28 (table 7.7).

The five patients being observed represented a relatively high proportion of the overall workload during the 24 hours, with a ratio of 0.33 (tables 7.2, 7.5). However, no first year students were on duty during the observation session and interactions were undertaken by either trained staff or senior students. As in the afternoon session described above, the high psychosocial scores appeared to be favourably influenced by the skills and preferences for identifying patients' affective needs and doing emotional labour by one particular nurse. In this case, she was a third year student awaiting her state final results. Furthermore, the ward sister's presence on the evening shift, and her involvement in giving direct care to the patients, also appeared to influence favourably the overall care score.

Kinder ward (Tables 7.3, 7.6, 7.7)

Morning session

During the morning observation session, Kinder achieved its highest QualPacs score (4.5, table 7.7). Workload was at its lowest for any other ward or for any other day during the 24 hour period in which the observation session took place. The psychosocial care score (4.3) was slightly below the overall care score of 4.5 (table 7.7). However, 4.3 represented the highest score achieved for psychosocial care, compared with the psychosocial scores achieved for the other two sessions undertaken on Kinder. No first year students were on duty during the morning session, the most junior staff being second year students (table 7.3).

Although the overall workload on Kinder was the lowest of any other ward for the 24 hour period in which the observation took place, the four patients being observed generated the highest workload of any others observed on any other ward and at any other time. They represented a ratio of 0.42 of the total workload in the 24 hours during which the observation took place (tables 7.3, 7.6).

Over 50% of the interactions were undertaken by senior third year students and trained staff. It may be that the seniority of the staff on duty interacting with the observed group of highly dependent patients, together with the relatively low workload generated by other patients on the ward, enabled them to maintain a high quality of nursing.

Afternoon session

A high QualPacs score (4.3, table 7.7) was achieved during the afternoon observation session at 4.3, with a similar workload (58 hours of patient care required in 24 hours, table 7.3) to the morning session described above but with fewer staff (15 person hours less). The psychosocial care score was at the lower end of the range for the total number of sessions on all three wards at 3.9 (table 7.7). There was only one first year student on duty during the session, in addition to two trained nurses and four third year students (table 7.3).

The three patients observed represented a ratio of 0.34 of the total workload (tables 7.3, 7.6). Just over 28% of the interactions were undertaken by a first year student alone, suggesting that the majority of the interactions were carried out by trained staff and third year students. It appears therefore that the prioritisation of meeting patients' affective needs and doing emotional labour on this occasion was not favourably influenced by the seniority of the staff interacting with patients. Rather, the overall care was dominated by technical activities such as drug administration and nasogastric feeding. A

doctor's round was also taking place during the observation period which appeared to disrupt nurses' psychosocial interactions with patients and possibilities for emotional labour. The ratio of psychosocial care to overall care was at the lower end of the range at 0.25 (table 7.7).

Evening session

The lowest overall QualPacs score, 3.6 (table 7.7), for either session or ward was achieved during the evening observation session on Kinder. However, the psychosocial care score was more favourable at 4.1, as was the ratio of psychosocial care as a proportion of overall care at 0.35. Circumstances which appeared to militate against overall higher scores were a higher workload on the ward during the 24 hours of the observation session, although associated staffing levels did not appear unduly low (table 7.3). The ratio of trained staff to students at 0.33 for the session being observed was the same as for other wards during the evening.

The four patients observed represented a ratio of 0.24 of the total workload in 24 hours (tables 7.3, 7.6). Only a quarter of the total interactions were carried out by a first year student alone. Additional reasons for the lower score, other than level of experience of staff and workload, were sought. During the observation period, for example, two of the staff were not consistently available to provide direct patient care. Sister Kinder, who was also responsible for the coronary care unit, was involved for part of the observation period with transferring patients between the unit and the ward. One of the third year students took over largely administrative duties during the observation period in preparation for a forthcoming management assessment. Consequently, a third year student and a first warder were left to undertake the majority of direct patient care on the ward, including the drug round and supervision of patients' suppers. The

increase in the proportion of care that was psychosocial for the patients under observation appeared to be related to the personal preferences and skills of the senior third year student. This observation session provided an example of circumstances (changes in patients' condition; perceived student learning needs) which militated against the overall quality of care.

Conclusion

The inferences drawn from the QualPacs data discussed above are based on very small differences between scores that were not statistically significant. The methodological and theoretical issues surrounding QualPacs as a valid and reliable measure of quality of nursing have already been discussed in chapter 2, section 2.1.2, and chapter 3. It is also possible that the high scores obtained during non-participant observation on three study wards reflect, not only the QualPacs design by which only item cues of positive care across the range 5 to 1 are aggregated, but also the researcher's positive bias towards the nurses being observed. In an eight week period of participant observation on each ward, it is likely that bias in favour of the ward nurses developed as a consequence of a 'halo effect' created by the nurses' friendliness towards the researcher.

During interview (see section 7.1 above) the patients also described the City nurses as 'friendly' and used this characteristic, among others, to judge positively the quality of nursing.

The QualPacs data, therefore, are of limited value on their own and are not used here to say anything substantive about the differences in quality of nursing on three wards. Rather, these data are used to discuss aspects of quality, yielded from observing the process of care using a quantitative measuring instrument during different times of day and on three different wards. The findings, based on only three observation sessions per ward, are not generalisable in themselves. The

aspects of care that they highlight, especially in relation to the psychosocial dimensions of nursing, as well as the validity of the QualPacs authors' conceptualisation of the quality of nursing, are questioned in the light of data yielded from participant observation and interviews, presented in section 7.2.2 below.

However, the QualPacs instrument which purports to measure the process of care, when used in conjunction with data yielded from recording the structure for care (Barr Dependency checklist; staffing levels and mix), allow inferences to be drawn about the abilities of students to give high quality nursing at different stages of training and/or its relationship to their supervision by trained staff.

7.2.2 The quality of nursing explored through participant observation and student interviews

As stated in the introduction to this chapter, additional data collected during observer participation and student interviews are presented in the form of patient care vignettes. These data permit an exploration of quality of nursing and the emotional style in which it is given, according to the technical, basic and affective work undertaken by nurses. The affective components of nursing are elaborated, drawing on Strauss et al's (1982b) notion of sentimental work, as described in chapter 2, section 2.1.1 (see p.24). The data also permit an exploration of the interaction between particular ward environments in terms of the nature of the nursing work (chapter 5) sisters' management styles (chapter 6), and students' ability to give care at different stages of training. Medical interventions and responsibility for patient care are not considered in any detail here.

Findings are presented for each of the four study wards.

Edale ward

The analysis of data to illustrate quality of nursing, with patient care vignettes, suggests that the sister's management style and the type of patients on the ward, many of whom generated emergency

situations, did not always permit a clear distinction to be made between technical and affective nursing. A third year student commented on the affective (psychosocial) care of the patients on Edale ward, in the following way:

On a patient-nurse basis, it's good, as any other ward. But the trained staff are not madly geared to that sort of thing. They run the ward on a scientific approach, so psychosocial care is included.

The student's view of the content of nursing work on Edale ward suggested that affective patient care was not part of the explicit 'sentimental order' of the ward, as described by Glaser and Strauss (1965).

During the study, a number of patients were admitted with a history of drug use and overdose. Seventeen year old A* was one such patient. A drug overdose of heroin brought him into Edale whilst the researcher was undertaking observer participation. He had a two year medical history of epileptic fits following a road traffic accident. During his current admission it soon became clear that he was prone to respiratory arrests, probably associated with illicit drug taking. His friends continued to bring drugs for him during his hospitalisation. When the physicians found out about this, they warned A that if he continued to take drugs whilst he was in hospital, he would have to be discharged. A was also under the care of the psychiatrist and social worker who offered him the possibility of being referred to an adolescent unit to treat his drug use. A could not bring himself to take on that commitment. Consequently, he remained in the general ward for the treatment of his epilepsy and resuscitation from repeated respiratory arrests. After six days, A discharged himself.

* Initials are used throughout the ward case studies to represent the way in which nurses addressed the patients, i.e. with titles or by first name.

Less than a day later, A was readmitted in police custody. He had been arrested for shoplifting and taken into custody, from where he was readmitted to Edale ward following more epileptic fits. Hence A was accompanied at all times by a police officer, until bail was granted. He remained in hospital another two weeks, during which time he continued to suffer from epileptic fits and periodic respiratory arrests. His behaviour was unpredictable and he would walk off the ward when no-one was looking. Once he was found in the basement of the hospital, unconscious, following an epileptic fit. His behaviour, coupled with his unstable medical condition, caused the nurses great anxiety. Following one particular arrest and resuscitation which the researcher witnessed, Sister Edale suggested that A's resuscitation following repeated respiratory arrests was 'a waste of resources' given his lack of motivation to seek treatment for his drug dependency. The sister made this comment in the privacy of the office and never gave any overt negative cues about A to nurses during handover report. Furthermore, she was observed, following the arrest and resuscitation referred to above, to draw the curtains round A's bed whilst she washed him and talked to him about what had happened. Sister Edale was alone with A for some time. The next day he bought her some roses as a token of appreciation for what she had done.

Indeed, the nurses who cared for A were supportive towards him. One student described him as 'not a bad lad' whilst another proclaimed that she was 'on his side' as she made his bed with the researcher. A first warder who was on the ward on a number of occasions when A had a respiratory arrest said:

The staff nurses took it all in their stride, no-one panicked, and afterwards anyone senior to me came up and asked if I was all right. Other students also said they felt well supported by the trained staff, who were observed to cope competently and efficiently during A's

arrests. A appeared, therefore, to receive technical and emotional labour from both trained staff and students during his stay in Edale ward.

Nurse N, a first warder on Edale ward, four months later, gave a different account during interview of the care of another young drug user as seen from her view point. Although the students were different from when the researcher was on the ward, the ward sister and most of the staff nurses were the same.

First of all, N described the difficulties she encountered in the other nurses' attitudes towards drug users. She said:

They (the nurses) just have a preconceived idea that all people in that situation are just a waste of time ... one nurse thought, you know, that it was all a working class problem and why should they be treated.

N was asked if such attitudes were discussed at ward level. She replied in the negative. She went on to describe how she was asked by a doctor to talk to a patient who was a drug addict because 'the staff nurse said you seem to handle him so well'.

N also described an incident with this same patient in which she was asked to 'keep an eye on him' whilst he was sitting in the day room and requested by the trained staff to 'please let us know if he becomes violent'. According to N, the patient began to have withdrawal symptoms and crawl on the floor. When asked if she received any support from other nurses, N replied: 'One of the staff nurses was great, but the student nurses, no, no way'.

The two accounts of the care of drug users admitted to Edale ward present similarities to Strauss and colleagues' (1982b) classifications of sentimental work and the conditions under which it takes place in the illness trajectory. In the case of A, 'biographical' and 'identity'

work* were undertaken by the sister.

According to Nurse N, the second patient was the target for moral judgments based on age, gender and life-style cues of the type which, according to Strauss et al, occurred in emergency rooms where minimal biographical information was obtained because of the gravity and urgency of the patient's condition.

Nurse N talked also about an 82 year old patient, Mr B, who had been on Edale ward at the same time as the researcher. Mr B, who had a history of cancer, had been admitted with 'weight-loss'. He was described in the ward report as 'self-caring'. However, after four days in hospital, one of the nurses reported that she found Mr B sitting in the toilet, unable to walk back to his bed because he was in such severe pain. It became apparent that not only was he reluctant to tell anyone about his pain but also to take any analgesia to relieve it. After this incident nurses were instructed during the ward handover to 'observe whether Mr B is in pain or not'. By the time the researcher left the ward, Mr B was accepting regular analgesia. That his condition had deteriorated and that he was unlikely to recover was indicated by a medical decision that he was no longer to be actively resuscitated. That he was at least partially aware of the situation was apparent in his remark to a nurse that he hoped that he would become a grandfather soon. In the context of the conversation, he implied that he might not have much longer to live. The cause, control and implications of his pain never appeared to be clearly discussed with him, during the time the researcher was on the ward.

Mr B was readmitted to Edale ward in the terminal stages of cancer,

* Described by Strauss et al (1982b) as moving imperceptibly into each other but analytically distinct in that the former pertains to getting personal and social information whereas the latter refers to working with the patient on matters of personal identity (p. 262-264).

four months later, during Nurse N's time there . She talked about him to the researcher. She described how:

I sat and talked to him for a while. I was trying to think of what to say to him. He was in a lot of pain. He won't accept his diagnosis.

As N described Mr B's situation it appeared that his needs, apparent during observer participation, had not been resolved. N was asked if she discussed her difficulties in talking to Mr B and his needs during the handover report. She replied 'Not as much as we should'. In Mr B's case it appeared that, in the absence of a nursing problem requiring a technical solution, the need to do sentimental work of the biographical and identity type was less likely to be recognised on Edale ward. Whilst N, a junior nurse, recognised the need to do such work, the lack of its visibility in the sentimental order of the ward meant that she was not held accountable or encouraged to follow it through. Under such conditions, emotional labour (Hochschild 1983) which, as stated in chapter 2, section 2.1.1 (see p.34), is conceptually related to the notion of sentimental work, might be withdrawn.

K, a third year student who was allocated to Edale ward one month after N had left, provided an example of patient management which suggested that the lack of explicit recognition and support by trained staff to do sentimental work culminated in the withdrawal of emotional labour. The researcher observed a critical incident session in the school of nursing (chapter 4, section 4.3.2, p.182) in which K participated, just after she had left Edale ward. She described a patient who was over six feet tall who walked about in his underpants. K interpreted his behaviour as sexually suggestive and potentially violent. She felt that one reason for this was because she was only five feet tall. K said:

I learnt something about myself - I felt I had failed. Never before did I realise that there were certain patients I just couldn't cope with.

She described how the doctors offered psychiatric help to the patient, and when he refused it 'kept away from him as much as possible. In the end I couldn't go near him either'.

K decided she could not do any affective/sentimental work with this patient and withdrew her emotional labour, which resulted in a sense of her own failure.

The final vignette describes patient D, aged 42, who was dying of renal failure after three years' treatment for a renal condition. He had had repeated admissions to Edale ward and he and his family were well known to the sister and trained staff. Strauss and colleagues (1982b) identify a patient's periodic hospitalisation to the same ward as one of the conditions under which biographical work is more likely to take place. Indeed, when Sister Edale was about to go off duty for a few days, she asked the staff nurses to ring her if his condition deteriorated. She said that she did not want to miss saying good-bye to him, just because she was off-duty. However, D survived a few more days. There was much discussion during ward handovers, about his need for analgesia, his feelings about dying and making sure his wife would be with him when he died. He was offered diamorphine to relieve his pain, but he requested pethidine instead. His wishes were respected. D was moved into the only side ward on Edale ward and, on what was to be his last day, a staff nurse was with him all the time. She helped his wife to give him a bed bath.

It was suggested by the sister that D recognised that he was dying, in that he uncharacteristically agreed to be bathed by other people, rather than doing it himself. The staff nurse who was with him on that day told the researcher that she hoped she would not be on duty when he died. In fact she was not. He died at 10 o'clock the same night, to the great sadness of the trained staff and his wife (who was with him).

D's dying and death appeared to be have been handled sensitively by

the trained staff, who knew him well and provided an example of 'identity work'. Students were not allocated to care for him during his last days.

These accounts suggest that nurses at all levels decided how much emotional labour they were able to invest. However, the recognition of patients' affective needs, as different types of sentimental work which required emotional labour, was not systematically discussed during ward handover reports between trained staff and students on Edale ward. When patients' affective needs were acknowledged and discussed by trained staff, students were better able to maintain quality of nursing through the emotional style in which it was given. When their emotional labour was not recognised or supported students were more likely to withdraw emotional labour.

Windermere ward

Data presented in chapter 6, section 6.2.2, illustrate that Sister Windermere placed great emphasis on interpersonal communication between both staff and patients. The analysis of data to illustrate quality of nursing through patient care vignettes confirms this finding. The vignettes are used to discuss the ward sister's role in the different components of patient care. The contribution of trained and student nurses is also discussed. The vignettes are based largely on data yielded from observer participation.

The following vignettes illustrate that identifying patients' affective needs and doing emotional labour, as a component of nursing, were highly visible, valued and part of the 'sentimental order' of the ward (Glaser and Strauss, 1965). The vignettes also illustrate that because many of the patients on Windermere were physically dependent and required large quantities of so-called 'basic' care, physical labour was also highly visible. Both trained nurses and students were constantly required to assist patients with their activities of daily

living. This included several suffering from senile dementia. The workload rarely decreased throughout the 24 hours and, although nurses were observed to spend some time in the afternoon talking to patients, they were frequently called away to assist with lifting or fetching a commode.

The first patient care vignette describes Mrs K, who was 69, Armenian and a former nurse. She had been treated in the past for breast cancer and was known to Sister Windermere from previous admissions. She was admitted on this occasion for the treatment of a pleural effusion due to either tuberculosis or metastases. She was suffering from back pain, difficulty in sleeping and breathlessness. Mrs K was a self-contained woman who appeared reserved and controlled. She was in hospital for six weeks before she died. Her pain control was monitored and changed with a variety of drugs until in her last few days she was offered diamorphine, which she finally accepted on the day she died.

Mrs K was seen in the early days of her stay by the social worker and the possibilities of hospice care were discussed but refused by the patient and relatives.

The ward handovers showed an early acknowledgement by the trained and student nurses that Mrs K was 'low, miserable, distressed', but there was also a persistence in caring for her physically, with instructions such as 'needs bullying to be on her side'; 'must be sat with and made to eat'. She also began to acquire the label of 'being demanding'. As nurses walked by she would call and ask for different things: her pillow to be straightened, a glass of water, the commode. It was rare that she could let a nurse walk by without asking her for something, and always in a monotone and unsmiling. Nurses were observed to respond to Mrs K's requests and did not appear to ignore her, but they had the minimum contact possible with her in that they fulfilled

her requests as quickly as possible. When lung secondaries were confirmed and she was asking 'if it would be like this to the end', the sister said she would speak to her, providing an example of 'identity work' (Strauss et al, 1982b).

When a third warder described Mrs K as 'demanding' at the lunchtime report, the sister asked the group why she might behave in this way. A second year thought she might be 'nervous', whereas a third year thought it might be an 'automatic response'. The sister advised the students to approach Mrs K first, in order to reduce her need to 'demand'. The discussion of patients' affective needs during the handover reports provided an example of what Strauss et al (1982b) describe as sentimental work being made officially visible to others which made it an accountable item for future trajectory work (p.267).

Within a week, Mrs K's condition had deteriorated and her family was alerted. She received the last sacrament of the Armenian orthodox church and the staff on the night shift understood clearly that her relatives did not want to be called if she deteriorated in the night. The researcher was present on that night shift. Although Mrs K was quieter, she was still self-controlled and self-contained even to the point of refusing the diamorphine. The nurses on duty that night said that Mrs K made them feel guilty because they felt uncomfortable with her demands. The nurses' feelings supported Kelly and May's (1982) suggestion that 'the role of the caring nurse is only viable with reference to an appreciative patient'.

The researcher was not present when Mrs K died. The sister said that she resisted the diamorphine until the end and that her daughter was with her when she died.

Although there were some attempts by the ward sister to challenge the students' tendency to label patients, as illustrated by the way in which Mrs K's affective needs were identified and discussed, there

seemed to be demands imposed from both sides: nurses on Mrs K as well as Mrs K on nurses. Neither party expressed positive emotion towards each other. The fact that Mrs K was herself a nurse was rarely acknowledged. Furthermore, the nurses felt uncomfortable with Mrs K's demands, particularly as they could never seemingly satisfy them.

The case of M.D. offers an example of a patient whose affective needs were identified and emotional labour invested in order to manage severe pain. M.D. had been in Windermere ward for nearly two months at the beginning of observer participation, and was still there when the researcher left after a further two months. She eventually was discharged home. She was in her late seventies and had a history of bilateral mastectomies for cancer, a fractured hip, osteoporosis, and was currently being treated for pancreatic insufficiency, gallstones and obstructive jaundice. Her pain was kept under control by regular administration of palfium.

Halfway through the study period, M's pain became more severe and was associated with a general decline in her condition. She was given blood transfusions for low haemoglobin and it was thought that she might be suffering from internal haemorrhage. At the handover report Sister Windermere, who knew M well, wondered if her pain was 'true or anguish' pain. She was certainly worried about her prognosis and had expressed disgust with the doctors for not discussing her future adequately with her.

M's pain became so severe that she was given diamorphine regularly for a week. Students reported that she was suffering from possible 'withdrawal symptoms' when diamorphine was discontinued, because she was observed to be pulling on her infusion tubing. Whether or not M suffered from 'withdrawal symptoms' was never confirmed during handover reports but the effects of other analgesia given to control her pain were carefully monitored by the sister and changed if it appeared to be

inadequate. When M was at her lowest ebb, Sister Windermere not only discussed her pharmacological pain control but sat with her and held her to comfort her. Eventually, by the end of the study period, she was well enough to get dressed in her own clothes, take an interest in her appearance, and required minimal analgesia.

The type of sentimental work undertaken with M.D. again provided an example of identity work, largely undertaken by the ward sister. Sister Windermere was also able to help students' to meet the patients' affective needs by a system of verbal handover which made sentimental work officially visible to other nurses and an accountable item in patients' illness trajectory.

Another example of identity work and the conditions under which it took place is illustrated by the case of Mrs M, a woman in her fifties. She had been transferred to Windermere ward from a genito-urinary ward where she had been admitted for investigation of incontinence. A routine chest X-ray in preparation for surgery revealed 'a shadow on the lung'. Mrs M was now in Windermere ward for respiratory investigations. She was extremely anxious, developed an acute febrile respiratory condition and feared that she was suffering from cancer. The sister was observed to talk at length on a number of occasions with Mrs M about her fears. One of the students reported during the handover report that Mrs M had told her that she had been dreaming about dying. The system of handover in operation on Windermere ward, and the sister's interest in sentimental work, permitted Mrs M's fears and anxieties to be made known to all the nurses and the most appropriate strategy for supporting her was discussed.

The conflict between Sister Windermere's and the students' priorities is discussed in chapter 6, section 6.2.2(b) and (c). To some extent, the conflict of priorities on Windermere ward related to the demands of physical labour at the expense of emotional labour with its

implications for quality of nursing. The following vignette illustrates this point:

Z, a student waiting to take her state final examinations, wondered to the researcher on the first day of her allocation to Windermere ward how she was going to 'stand it' for twelve weeks. She referred not only to the perceived lack of patients with 'interesting' diagnoses, but also to the physical and emotional demands of looking after old people who were both physically and mentally dependent. She gave the researcher an example of Mrs L, who was 93 years old, suffering from a stroke and a fractured tibia and fibula. When Z spoke to her, she said she had no way of assessing whether Mrs L was understanding her or not. She had been feeding her with porridge for breakfast on two consecutive mornings. On the first day the patient ate her porridge. On the following day she proclaimed she detested it.

Z did not take this issue up during the ward handover report, even though communication between patients and staff was made a priority during these handovers. Rather, she told the researcher about her feelings later that afternoon during an informal interview to give feedback on a QualPacs observation session in which she had been involved that morning. She also described how she felt she had so much work to do and not enough time to do it in, that in her frustration she kicked a stool that was standing in between the beds of two of her allocated patients. One of these patients told Z that she thought she had kicked the stool because she was angry with her. The student reassured the patient to the contrary. This incident was an example of temporary withdrawal of emotional labour as a consequence of what the student experienced as too much physical labour. The student withdrew emotional labour because she was frustrated and the patient interpreted the withdrawal as an expression of anger against her.

The final patient care vignette is an example of ward orientation

towards physical and emotional labour possibly detracting from technical labour. Mrs T was admitted to Windermere ward for an inguinal hernia repair. She was admitted to a medical rather than a surgical ward because she was receiving treatment for hypertension from one of the Windermere consultants. Her post-operative recovery was slow and the diagnosis of intestinal obstruction took some days to be recognised. Third year students told the researcher that they wondered whether the delay in recognising Mrs T's signs and symptoms was associated with the ward's medical rather than surgical orientation. This proposition was further supported by one of the staff nurses, who did not notice that the drainage system from Mrs T's wound had become disconnected.

These accounts suggest that Sister Windermere chose to recognise and make visible patients' affective needs and invest emotional labour as an important component of nursing. Trained and student nurses were encouraged to do the same and were made accountable through ward handovers and reports. However, the heavy workload which generated the need to do large quantities of physical labour sometimes militated against the students' abilities to do emotional labour. The need to do technical labour was also a lower priority on Windermere ward, as a consequence of both the nature of the nursing work generated by patients and the sister's work preferences.

Ronda ward

Data presented in chapter 6, section 6.2.3, illustrate that Sister Ronda operated a management style that put priority on the technical and physical components of nursing, rather than on patients' affective needs and emotional labour. Since many patients on Ronda ward were suffering from malignancies and a variety of gastro-intestinal disorders, the need to recognise their affective needs and do emotional labour for patients in pain and/or dying, was frequent. The need to

emphasise the technical aspects of care was apparent for those patients admitted to Ronda ward for investigations and/or treatment of biliary conditions using endoscopic retrograde cholangio-pancreatography (ERCP). In addition, almost a quarter of the beds on Ronda ward were occupied by dependent elderly patients requiring nurses to do physical labour.

Patients' affective needs and emotional labour were not explicitly given priority and discussed during ward handovers and reports as part of the sentimental order of the ward (Glaser and Strauss 1965). However, the analysis of data to illustrate quality of nursing through patient care vignettes confirms that the recognition of patients' affective needs and investment of emotional labour still occurred amongst all levels of nursing staff on Ronda ward, including the ward sister.

R was a thirty year old patient admitted for the surgical treatment of pancreatitis. Both pre- and post-operatively the patient complained of abdominal pain for which he was prescribed pethidine. The researcher noted a reluctance on the part of students to respond to R's requests for analgesia. This reluctance appeared to be particularly marked for other patients like R, if the analgesic was a controlled drug and/or if they were suffering from pancreatitis. These patients were described by one staff nurse (who appeared to represent the views of other trained staff on Ronda ward) as 'wimpish, friendless and hooked on pethidine'. It is likely that this view was implicitly transmitted to the students who did not respond sympathetically to patients such as R, possibly seeing the pain as 'caused' by personality defects rather than by pathology. When doctors withdrew R's prescription for pethidine some days following surgery, a third ward student described him as a 'pain' because he was questioning the doctor's decision. R also told the researcher during interview that first year students would ask him if

he 'really needed' his analgesia, suggesting that he 'shouldn't really be having pain' post-operatively.

The sister, recognising his anxiety, called R into her office to discuss his pain control with him. She reassured him that he could continue being prescribed pethidine for a while longer, explaining the junior nurses' response as due to inexperience. R expressed relief that Sister Ronda's explanation had helped him to understand that the pain he was experiencing 'would take a long time to resolve' and was not 'a figment of my imagination'. He also added that Sister Ronda gave him information that even the doctors overlooked. Following her interview with R, the sister contacted the doctors to ensure that he was prescribed pethidine for a longer period since other analgesia had proved ineffective.

The sister's interaction with R provides an example of what Strauss et al (1982b) describe as 'rectification work'.* Sister Ronda did not appear, however, to make the sentimental work that she did, with R or other patients, officially visible to more junior staff even when she counted it as an accountable item of their care. As mentioned in chapter 6, section 6.2.3, the sister told the researcher that she considered it the students' responsibility to see that patients' needs were met. If she noted omissions in care, of whatever nature (technical, physical, affective), she would undertake to make good those omissions rather than ask the students to do so. This appeared to be her strategy in the case of R, although she had assured him that she would explain to the nurses the importance of him receiving regular analgesia. On one occasion, Sister Ronda asked the researcher if she

* Another staff member picks up the pieces after rude or thoughtless personnel, or in this case inexperienced staff, have shattered the patient's composure (p.265).

had observed the inadequate way in which nurses sometimes talked to patients. She did not, however, discuss alternative approaches during the ward handover reports.

In the context of Mr I, the unpopular patient who was described by another patient as creating a 'bad' atmosphere on the ward (see section 7.1), Sister Ronda talked to the researcher about Stockwell's study (1972) of the unpopular patient. She demonstrated an understanding of the processes involved in labelling patients as 'unpopular', but was not seen to talk to Mr I about the reasons for or the consequences of his behaviour. One patient actually commented to the researcher that Mr I should, in his opinion, be given a talking to by the 'higher-ups'. Mr I continued to be disruptive until his discharge, without any clear reasons for his behaviour being articulated during ward handovers.

In the case of dying patients, the sister identified a technical solution for minimising their pain. She had bought an infusion pump with ward funds that could be used to administer analgesia such as diamorphine on a continuous basis. The use of this pump was seen to be effective in controlling the pain of one patient dying of carcinomatosis, during observer participation. A third year student on the ward four months later also described, during interview, the pump's effectiveness in assisting 'a lonely old soul who had been gasping for breath ... to die a lovely death'.

Although the sister clearly recognised patients' affective needs and invested emotional labour with individual patients, the following vignettes suggest that much of the direct emotional labour associated with dying was handled by students. This was in line with the sister's policy of deflecting responsibility to students to ensure that patients' needs were met.

A third year student, M (module 14), for example, told the researcher that she looked upon laying out patients as her last duty to

them. This was why she was pleased to be able to lay out one of the long term patients, a 50 year old man who had died from lymphoma. She also described how she had talked to a young patient who was very upset about the death of this man. According to M, he had 'sat on' his feelings unnoticed for about a week before she spoke to him and discovered that he was 'all chewed up' about the death.

M's account suggests that as an individual she was able to identify the need to do identity work and invest emotional labour with patients concerning death and dying. The researcher's observations confirmed this finding.

The case of Mr O, however, offers an alternative perspective on students' direct handling of death and dying, the consequences of which appeared to 'fragment' his care. The patient was in his fifties and known to the ward staff from previous admissions. He was admitted in the final stages of liver failure. A first year student (module 1) described to the researcher that when the nurses realised he was dying a finalist had suggested that she should hold his hand, which she did. However, she did not assist in laying him out because a finalist had not yet performed last offices and 'needed the experience'. The first warder said that all the staff had asked her afterwards if she felt all right. She said she had felt sad.

Thus, the patient's affective needs were identified by a third year student, but the associated emotional labour was delegated to a first warder. The learning needs of another third year student intervened, preventing the first warder from following through her care of Mr O to its conclusion.

The vignettes which follow illustrate that the students' ability to invest emotional labour even without the supervision of trained staff depended to some extent on the patients' own responses to the students' labour.

Mr L, a man in his eighties, was transferred from a provincial hospital for ERCP and insertion of a stent to relieve obstruction caused by a large tumour in the biliary tree. He was reported to be unaware of his diagnosis. Soon after his admission his son had a myocardial infarction and died. Mr L became profoundly depressed, withdrawn and tearful. All these facts were transmitted in the handover report and nurses were instructed to 'chat' to him. He did not attend his son's funeral because it was said that he did not wish to go. A staff nurse remarked to the researcher that she now avoided talking to Mr L because when she did he started crying.

Inferences may be drawn from first year student L's (module 3) perception of Mr L that his profound distress and depression were dealt with only on a superficial basis by the sister and trained staff, with the result that the students felt helpless to support him:

From the moment I nursed him, he just wanted to give up life altogether; he was very apathetic, I'd say. There was nothing you could do. I used to go and sit and talk to him if I had time ... but he was just not willing to talk ... he didn't even want to talk ... he wasn't one of those patients who bottled everything up and then came out with it. He just gave one word answers all the time and you felt you weren't getting anywhere and you felt: well, he was eighty or whatever and it's his choice, really ... I've always heard that people could give up and just turn their backs or whatever, but that's a real classic case.

Mr L began to vomit blood after being in Ronda ward for about 12 days. At this point the doctors wanted to transfer him back to the provincial hospital but he died later that night before they could do so.

The researcher had also experienced the difficulties of talking to Mr L and understood why student L might have felt that:

... he was just rejecting me totally, and you felt as if you were imposing on his privacy ... he kept the curtains half drawn as well and I always felt: this is not my position, to come here.

Mr L's case was an example of the nurses' recognition of the need to do emotional labour but the lack of guidance and support on how to invest it. The difficulties on the part of the staff in talking to him about either his own or his son's death has similarities to another category

of sentimental work described first by Glaser and Strauss (1965) and more recently by Strauss and colleagues (1982b) as 'awareness context work'.* Thus, it may be inferred from L's account and the researcher's observation that the quality of nursing as received by Mr L lacked adequate emotional care.

On the other hand, the case of Mr B illustrates how first year students L (module 3) and M (module 1) gave high quality nursing, as indicated by the sensitive way in which they handled his death and his wife's bereavement. M said she had been with Mr B and his wife as he was dying. She had decided of her own accord to take his pulse regularly to reassure his wife that something was being done. The following day (the day that the researcher organised a ward based discussion), L had seen Mrs B by chance in the front hall of the hospital. She was crying. L invited her back to the ward 'because the hall is very impersonal'. She had observed relatives being treated in a similar manner in the ward across the corridor from Ronda. L went on to say:

Mr B was very comfortable when he died. He was very grateful and easy to nurse; he was a lovely man. His wife said she wanted to tell us that 'he always said to me how good you (nurses) were'.

This quotation confirms yet again that the caring role of the nurse is only viable with reference to an appreciative patient (Kelly and May 1982).

The case of J provides an example of students' direct involvement in doing emotional labour, with aggressive patients. J, a man in his forties, was admitted with episodes of confusion and aggression. The cause was unclear. He was a bomb disposal expert in the army and there

* Withholding of information by staff which they believe will be difficult for the patient to handle and/or disturb personnel's comfort or composure, p.265.

was some suggestion that his behaviour was a reaction to the stress of his work. He was tall and students described him as 'good looking'. He would wander off the ward and any attempts at restraint might precipitate aggressive and 'threatening' behaviour.

Third year students, M and E (module 14), were on a week of night duty together with no trained staff on the ward. They were required to manage a group of patients which caused them particular stress. In addition to J there was another confused patient recovering from acute liver failure and also likely to wander off the ward, and it was the week that Mr L deteriorated and died. The staff nurse told the researcher that she realised that E was stressed when she overheard her talking to J at the end of her sixth night on duty. According to the staff nurse 'her voice cracked', and the next night she reported sick.

The following week when E was on day duty she complained that she was suffering from headaches. She discussed their possible cause with the researcher. She said that she had found difficulty in sleeping during the day because she had been so 'active' whilst on night duty. Also, her state final examination was imminent, which was making her anxious.

About J she said: 'You feel you can't say "look here, mate!"' (i.e. she was doing emotional labour by suppressing her negative feelings towards him). She said that, although the night sister had been very good in supporting her and M, she had had no help from the doctors. She also felt 'a bitter taste' because this week there was an extra agency nurse on night duty, which had not been seen as necessary when she had been on night duty. She and M had struggled on alone and could 'only just manage', even though they were able to assess that they needed extra staff. For E, like K on Edale ward, the costs of maintaining emotional labour when confronted by a potentially violent young male patient were high. K withdrew her labour by avoiding the patient, E

developed headaches and reported sick on her last night of night duty. The situation was exacerbated for E by other patients besides J requiring her to do emotional labour.

The analysis of data in relation to quality of nursing on Ronda ward suggests that, although the technical and physical components of nursing were given explicit priority, nurses at all levels, including the ward sister, identified care for patients' affective needs and invested emotional labour. However, the maintenance of control over the giving and handling of information by the sister and her own covert investment of emotional labour left students to identify the need to do various types of sentimental work and make their own decisions about whether to do emotional labour or not. The need for support to help students to realise that the sister identified affective/sentimental work as an accountable item requiring them to do emotional labour is apparent in the absence of a reporting system that allowed them to discuss all aspects of nursing with trained staff. These data support the findings presented in chapter 6, section 6.2.3.

Kinder ward

Data presented in chapter 6, section 6.2.4, suggest that Sister Kinder identified patients' affective needs during ward reports, but delegated emotional labour through the staff nurses and students.

The proximity of the coronary care unit to the ward and the large numbers of patients admitted for investigations and/or treatment of cardiac and metabolic conditions were reflected in the technical emphasis of their care. Furthermore, during the period of observer participation, there was an unusually high number of dependent elderly patients admitted to Kinder requiring nurses to undertake physical labour.

The analysis of the data to illustrate quality of nursing through patient care vignettes support these and other findings presented in

chapter 6, section 6.2.4, which suggest that much of the emotional labour on the ward was carried out, unnoticed, by students. This depended to some extent on how much they were able to invest and their own work preferences and priorities, since the ward sister did not make sentimental work either officially visible or an accountable item of patient care (Strauss et al, 1982b).

Two vignettes described below illustrate the invisibility and lack of accountability for the care of patients' affective needs on Kinder ward.

Mrs J had a long medical and surgical history for treatment of cancer of the cervix and bowel. The vignette illustrates that basic sentimental work categorised as 'interactional work and moral rules' (Strauss et al, 1982b) was inadequate.*

For two years Mrs J had had a permanent colostomy since an attempt to repair a vesico-rectal fistula. She had been admitted on this occasion to investigate the cause of low back pain. Although the nursing care plan included the regular administration of prescribed analgesia and the patient's expectations stated as 'Hopes back pain will be relieved', pain was not mentioned either in the handover or in the kardex for another ten days. The focus was on Mrs J's colostomy, which nurses described as 'leaking, causing her embarrassment, and which she looked after herself'. There were references to her emotional state - 'subdued, fed up, low' - but the consultant was reported as attributing her mood to 'lack of fresh air and mobility'. A climax came when there was confusion over whether Mrs J would have an intravenous pyelogram (IVP) and she was left in a state of uncertainty for two

* Defined as listening carefully to patients, explaining and building up trust (p.261).

days. It was during this period, whilst both patient and nurses were waiting for 'the doctors to make up their minds' that Mrs J was interviewed by the researcher. The reason she had been selected and had agreed to the interview was that she had originally been scheduled for discharge following the IVP. The day following the interview Mrs J was very upset and in tears, because it remained unclear whether she was going for the IVP. She pointed out that she had been admitted because of pain, and that nothing had been done about it. Whether or not the interview triggered the outburst with K, her allocated third year student, it did seem to precipitate the doctors into making a decision, orchestrated by the sister. After this incident, Mrs J's need for analgesia began to be mentioned in the handover report. She was finally transferred to a surgical ward for further investigations.

The second case study is based on a student's account of a patient suffering from pain and the student's feeling of being unable to persuade the trained staff to institute measures to relieve that pain. The student did not think that the patient was being given 'pain killers'. There is no way that the researcher could confirm this. However, even if the patient were being given analgesia, it was clearly inadequate. The student's inability to use the ward handover to secure pain relief for the patient has already been discussed (chapter 6, section 6.2.4(c)).

The student's account was recorded during an interview in the week after she had finished her allocation to Kinder ward. She was a first warder and perhaps because of this her insights were not taken seriously by the trained staff. They could no longer see the person behind the pain in the way that a new entrant to nursing still could. The student's account of the patient in pain was similar to the personal account of the patient described by Taussig (1980) who said that:

They (the doctors) don't feel the pain. They give an order what to do but they don't feel the pain. So they really don't know the type of hazard you're going through. (p.7)

Similarly, the student told the researcher:

I feel like I want to go out and change things already, like people in pain. What the hell! They're not going to get addicted ... You just kill the pain ... There was this woman in agony every time we moved her ... if only they'd have given her something to kill the pain just an hour before we moved her, then it wouldn't be so hard lifting her. That's what she's going to be like for the rest of her life, every day, the same old pain. What does it matter if she becomes addicted?

PS: Was it not possible to give her pain control?

It would have been possible; they just overlooked it ... they just thought she was sitting there normally (i.e. when she wasn't moved she wasn't in pain).

PS: Did they say she couldn't have the pain killers?

No ... they used to take her out of the ward (in a wheelchair) with her legs down ... and she was really shaking and I said 'Listen, I'll put the leg rest on ... that'll be better' and after that we started using it ... Nobody seemed to give her pain killers ... she was on a lot of tablets ... they weren't pain killers ... I think they (doctors) tend to be reluctant about pain killers, anyway. It's like curing them without a cure ... they're going to go downhill. She had Paget's disease, which is difficult to cure.

The above accounts appear to support even further the proposition that much of the emotional labour on Kinder ward was carried out by the students, often unacknowledged by the trained staff. As stated above, the amount of emotional labour that they invested depended to some extent on their own preferences and nursing priorities.

Student J, for example, was a mature entrant to nursing. Although she was only on her first ward she had had experience of living with a family as an 'au pair'. She had been employed specifically to look after the young children whose mother was dying of cancer. One morning whilst working with the researcher J said:

I'm much more interested in the social side of things ... making patients happy like B (a recently bereaved patient) ... there should be someone who can sort things out for her, sort out what's going round in her head. I'm more interested in what makes Miss S (another patient) grumpy than what's (medically) wrong with her. I don't find it satisfactory that it (the social side) doesn't have a focal point in care.

J's difficulties (like those of the first student) in discussing B's needs with ward staff are discussed in chapter 6, section 6.2.4(c).

Student J was interviewed at the end of her allocation to Kinder ward and gave further insights into her emotional labour with B, which could be categorised as identity work (Strauss et al 1982b) :

I was really quite upset about B's husband's funeral. I found that very frustrating, whisked off at the last minute ... I actually said to one of them (staff) 'she does want to go' and she said 'we've asked her and she doesn't'. But I said 'she's just told me she wants to go' ... and I thought, well, I had no say in it. And suddenly there was a great drama and laughs and giggles because she was got off in a taxi ... it was a mess but I couldn't do anything about it.

B was known to the researcher. She was observed to be stunned by her husband's death, which was partly a reason for her admission. The enormity of bereavement was never fully discussed in the ward report and the person who did the most emotional labour in helping her to sort out her tangled emotions was J, who was too junior, according to the trained staff, to be taken seriously. This incident, concerning the patient's wishes about going to a funeral of a close relative, is reminiscent of Mr L's situation on Ronda ward. Similarly, it was reported that he did not wish to go to his son's funeral as B did not apparently wish to go to her husband's funeral. However, through investing emotional labour student J elicited the opposite wish. It is open to speculation whether Mr L would have kept to his decision not to go to his son's funeral if more emotional labour had been invested than was evident in his care.

The final vignette concerns Miss B, one of the few black patients observed by the researcher. The vignette illustrates how labelling sanctioned by the trained staff can provide students with a strategy for withholding emotional labour, as suggested by the classroom discussion described in chapter 4, section 4.3.2 (see p.180). Miss B appeared to be such a target for stereotyping and labelling by the nurses. She was in her sixties, weighed over 16 stone, and was

suffering from a severe stroke. She was described as a 'big black mama' and 'a little gem' by the sister. Both doctors and trained staff seemed surprised at Miss B's white hair.

Miss B had been transferred from another ward and so her nursing history had been written there. It had been noted by the nurse taking the history that the patient 'had an aversion to men' and 'was occasionally violent'. These labels surfaced from time to time during the nurses' handover report, even though another history had not been taken by Kinder staff nor had Miss B shown either of the characteristics described. It was three days after her admission before a staff nurse challenged the assumption that Miss B had 'an aversion to men'.

She snored loudly at night which, together with her obesity and colour, led some patients to describe her amongst themselves as an 'animal'. Although staff were aware of this offensive label, they did not do anything to dispel it. They did not acknowledge overtly the racist implications of such a label. One remark during a handover report illustrates how racist stereotypes may actually threaten the physical as well as the psychological care of patients. The nurse allocated to care for Miss B reported that she had found it difficult to give her an injection because her skin was 'tough'. The inference drawn from this statement among the nurses was that 'black skin is tough' and therefore her pressure areas were more likely to remain intact. Two days later Miss B was reported to have 'a broken area' on her left buttock.

K, a third year student, who had been allocated to look after Miss B one morning shift, decided after washing the patient's hair to 'cane row' it for her. K's intentions suggested that she was sensitive to Miss B's cultural traditions. Unfortunately, K did not have time to experiment, since she did not know how to do it. As she was not

allocated to care for Miss B on subsequent days, she neither passed on the suggestion nor followed up what would have been a sensitive indicator of care. However, plans to obtain a brassiere to treat the soreness under Miss B's breasts was followed up by this same student, with the help of the sister.

The nurses were never openly unkind to Miss B and described her in the handovers as 'ever such a nice lady' and 'very pleasant and smiling'. After a month in Kinder ward a third year student reported that Miss B was upset when her choice of food from the hospital menu was limited because she was on a reducing diet. The sister gave the instruction to 'be more liberal'.

Although plans continued to obtain the brassiere for a further four weeks Miss B was due to be transferred to a stroke unit, without it having appeared.

At the end of the study period, the labels of 'violence' and 'aversion' to men began to be mentioned again during the handover reports. K, however, who had wanted to cane-row Miss B's hair, resisted these labels, reporting that there had been no evidence of either. The sister commented that a new male nurse on the ward had been unable to give Miss B a bath. The comment went no further and there was no discussion as to whether the patient's reluctance to be bathed by a young man might be justified. It seems with Miss B that, once her behaviour won the nurses' approval, the initial stereotyping and labelling were overcome. Her physical care was good, although her psychological care from the nurses remained minimal.

During interview, first ward student C mentioned that she had chosen to spend time sitting with Miss B, suggesting that despite her inexperience she had made her own choices about investing emotional labour with Miss B, irrespective of negative cues received during handover reports.

The analysis of data in relation to quality of nursing on Kinder ward suggests that the technical and emotional components of nursing were more likely to be identified by students than trained nurses. However, the ward sister, while investing in technical labour and identifying patients' affective needs during handover reports did not make meeting these needs either officially visible nor an accountable item of patient care. Neither was the sister observed directly to invest emotional labour with patients. Most of the emotional labour was undertaken by junior students with patients who were elderly and who also required physical labour to be undertaken as part of their care. On occasions, patients received minimal amounts of emotional labour. Junior students experienced the ward handover reports as inadequate for expressing their own contribution to and for receiving feedback on caring for patients' affective needs. These data support the findings presented in chapter 6, section 6.2.4.

7.2.3 Comparison of the findings on quality of nursing using alternative observational methods

The data obtained during non-participant observation using the QualPacs measuring instrument suggested that lower scores were associated with a higher number of patient interactions with first year students compared with more senior nurses.

The proportion of care that was categorised as physical, technical or affective/psychosocial was influenced by the nature of the work generated by the patients being observed, the management styles, work priorities and preferences of the sister on each ward and the work preferences and skills of individual nurses. Higher scores on the psychosocial dimensions of the scale in comparison to the overall care scores did not necessarily mean that the proportion of psychosocial to overall care increased.

The data yielded from participant observation and student interviews, using 'sentimental work' (Strauss et al 1982b) as an

analytical framework to classify, describe and specify the conditions under which affective/psychosocial took place, offered additional perspectives to the QualPacs data.

It was noted, for example, that on Ronda the QualPacs scores suggested that psychosocial care was of a higher quality and constituted a higher proportion of the nursing work than on either Windermere or Kinder. This finding was regarded as surprising given the data obtained during participant observation and interviews, which suggested that Sister Ronda gave priority to the physical and technical components of nursing whilst Sister Windermere placed great emphasis on nurses' interpersonal communication with patients.

Thus it appeared that data obtained during participant observation and student interviews, and presented as patient care vignettes, were richer and offered additional explanations for understanding the complex interaction between the work preferences and priorities of individual nurses; sisters' ward management styles; and the nature of the work generated by patients according to its physical, technical or affective components. These findings also describe why and how nurses undertook emotional labour and its personal cost to them. The findings suggest that nurses in their first year of training undertook substantial amounts of emotional labour that remained largely invisible and unacknowledged in the open arena of ward handover reports.

It appears from the QualPacs data that the quality of care given by first year students, as measured on the scale, reflected their inexperience as indicated by lower scores. The findings yielded from participant observation and interviews, using the conceptually related notions of sentimental work and emotional labour, suggest that the QualPacs measuring instrument failed to capture the relationships and the depth of emotional involvement between junior nurses and patients.

The findings are consistent with those reported in chapter 6 and

show that junior students were more likely to look after elderly dependent patients on a continuous basis compared with more senior nurses. Since the QualPacs scores suggest that the care given by less experienced students maybe of a lower quality, similar inferences can be drawn about the quality of care received by elderly patients. However, doubts have been raised on the validity of the QualPacs measuring instrument, in the light of findings obtained from data collected during participant observation and interviews. The inferences to be drawn from the qualitative findings suggest that it is more likely that junior students held a key role in terms of the quality of nursing being received by patients, because of the emotional style in which they cared for them. However, since patients' affective needs were not always made officially visible as accountable items of care by trained staff, students received limited supervision and support for the emotional labour that they invested.

The finding that the most junior students are the most likely to give care to long term elderly patients on a continuous basis is of particular significance when interpreted in the light of Miller's (1985) study of the nursing process. Miller showed that elderly patients hospitalised for more than one month benefited from nurse-patient rather than task allocation. It seems likely therefore that at City hospital the care of the longstay elderly patient was being given by the most junior students without adequate supervision and support from trained staff especially in relation to emotional labour, which was less visible than technical and physical labour.

Overall, the qualitative data confirmed exploratory work (chapter 3, section 3.3.3: see p.121) that quality of nursing could not be definitely operationalised into 68 items of care as prescribed by QualPacs. It was difficult to maintain 'objectivity' whilst rating items about nursing which involve feelings and emotions. Participant

observation also showed that a single QualPacs score was time dependent and not representative of nurse-patient interactions at other times nor under different ward conditions.

7.3 Ward Learning Environment Questionnaires: Student Ratings on Quality of Nursing

In this section the questionnaire findings are presented to provide additional evidence to findings obtained during interviews and participant observation. Firstly, table 7.8 shows scores or ratings obtained for section E of the questionnaire. For consistency, all scores shown in the tables are presented in original rank order of the overall scores (chapter 5, table 5.19). Figure 7.1, which accompanies the table, demonstrates the significance of the findings at the 0.05 level when mean scores were compared between pairs of wards using Gabriel's test.

Secondly, relationships between scores on different items and sections were tested using Pearson's correlation coefficient.

7.3.1 Section scores

The score relevant to describing quality of nursing was derived from section E (patient care) of the ward learning environment questionnaire. Students were asked to rate 'patient care' by allotting a score of 5 (most favourable) to 1 (least favourable) on five items, 31-35. These items were: Sister promotes good staff/patient relationships; Patients receive the best attention and nursing care; Patients get plenty of opportunity to discuss their feelings and anxieties; Nursing care is tailored to meet the individual needs of patients; and Patient allocation rather than task allocation is the practice on this ward. A mean score for section E was derived from the sum of the individual item scores, which represents aspects of quality of nursing, including meeting patients' affective needs, emotional labour and the nursing process.

Table 7.8

Students' ratings of 12 medical wards on Section E: patient care

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	4.28	.47
2. Eskdale	35	4.30	.52
3. Wastwater	34	4.35	.59
4. Ronda	43	4.19	.56
5. Edale	51	4.11	.57
6. Buttermere	35	4.38	.60
7. Ambleside	47	4.16	.60
8. Langdale	29	4.20	.66
9. Coniston	38	4.01	.65
10. Windermere	52	4.34	.55
11. Loughrigg	62	3.79	.68
12. Ullswater	50	3.63	.77

Figure 7.1

Gabriel's test of significance at the 0.05 level for comparison between scores obtained on Section E

WARD NUMBER	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	N	N	N	N							
6	N	N	N	N	N						
7	N	N	N	N	N	N					
8	N	N	N	N	N	N	N				
9	N	N	N	N	N	N	N	N			
10	N	N	N	N	N	N	N	N	N		
11	S	S	S	S	S	S	S	S	S	S	
12	S	S	S	S	S	S	S	S	S	S	S

S = significant at the .05 level. N = not significant.

Table 7.8 presents the range of scores obtained for section E from students' ratings of 12 medical wards. The scores for section E show a range from 4.38 to 3.63 (table 7.8). The three oncology wards and Windermere ward were the top four scorers. During interview, the students described the sisters on these wards as having a commitment to the nursing process and giving priority to patients' affective needs and emotional care (chapter 6, section 6.1). However, the differences in scores were only significantly different (figure 7.1) for the two

wards (Loughrigg and Ullswater), which had also obtained overall low scores on the ward learning environment questionnaire (chapter 5, table 5.19). It is possible that since students were observed to be, and perceived themselves as, the direct patient care givers, they were aware that they were assessing themselves as well as the ward staff by awarding these scores.

The inferences drawn from these findings are that differences in scores were only significant when wards received overall low ratings of the ward learning environment. The findings suggest that students' perceptions of favourable patient care and their own involvement in it were influenced by their overall view of the ward learning environment.

7.3.2 Relationships between scores

A number of two way relationships were examined using Pearson's correlation coefficient. Since interview findings presented in chapter 6 suggested that students perceived sisters' management styles as important to patient care, the relationship between score E (patient care, table 7.8) and section score B (ward atmosphere/staff relations, table 6.2) was tested. Item scores 4 and 6 (workload, staffing levels and mix, tables 5.21 and 5.22) and item score 36 (stress ratings, table 5.27) were also correlated with section score E to see if they influenced students' perceptions of patient care on a ward.

Section score B (ward atmosphere/staff relations) and section score E (patient care) were shown to be positively associated with a correlation coefficient of .67 ($p < .02$) which confirms findings obtained from an analysis of interview and participant observation data.

Perceptions of workload, staffing levels and mix (items 4 and 6) and stress ratings (item 36) were not significantly associated with patient care scores, as the correlation coefficients demonstrate: the correlation between item 4 (number of staff adequate for the workload) and section score E (patient care) was -0.12; between item 6 (enough

trained nurses in relation to learners) and section score E was -0.15; and between item 36 (stress ratings) and section score E was 0.25.

It might be inferred therefore that nurses compensate for feelings of stress, high workload and low staffing levels by seeking to maintain quality nursing through investing physical and emotional labour irrespective of personal cost.

These findings are consistent with an analysis of Barr dependency data during QualPacs (section 7.2.1) observation sessions and ward profiles (chapter 5, section 5.3) which suggest that the structure for care on a ward is constantly in a state of flux. They are also consistent with findings from students' responses to open-ended questions on the ward learning environment questionnaire, and presented in chapters 5 and 6, which suggest that relationships between pairs of variables measuring perceptions of stress, workload, staffing levels and mix, was complex. It is unlikely, therefore, that a statistically significant association between perceptions of patient care and stress, workload, staffing levels and mix would be obtained. The lack of association confirms the complexity of the relationships between these variables.

7.4 Summary of Findings

The findings obtained using the multimethod approach to data collection are summarised below. The findings address the conceptual categories of quality of nursing, the emotional style in which it is given, students' ability to give care at different stages of training and their interaction with associated variables (ward management styles, interpretation of the nursing process) described in chapter 6.

Quality of nursing and the emotional style in which it is given

The findings suggest that the principal indicator of quality of nursing was the emotional style in which care was given.

Top questionnaire scores for section E (patient care) were awarded to wards with a recognised commitment to emotional labour, i.e. the

three oncology wards (Wastwater, Buttermere, Eskdale) and Windermere. High stress, workload and staffing levels did not appear to be associated with lower patient care scores. Patient interview data support the findings that patients judged the quality of nursing on the emotional style in which it was given whilst recognising its cost, particularly when staffing levels were low and workload high, such as on night duty. Patients also expected to undertake emotional labour both on their own and nurses' behalf. Patients expected nurses among other characteristics to be loving, considerate, friendly, understanding and show interest in them. They considered that selection and hospital ethos rather than formal training accounted for these characteristics.

Patients recognised that students grew in confidence as they became more senior but relied on more senior nurses (who were not necessarily qualified) for guidance. They also recognised that they as patients were more likely to seek information from senior students and trained staff rather than from junior nurses.

The QualPacs scores suggested that quality of nursing was favourably influenced by more experienced nurses giving the care than first year students. However, scores also suggested that the psychosocial component of care was influenced by nurses' individual priorities and work preferences. Participant observation and student interviews suggested that first year students chose to care for dependent elderly patients with whom they invested substantial amounts of emotional labour that may not have been formally acknowledged by trained staff. The QualPacs scores suggested that even on Windermere, where the sister expressed an open commitment to identifying patients' affective needs and doing emotional labour, the proportion of psychosocial to overall care was less than half.

Students rather than trained staff were involved in direct patient care. Third year students were the hub of the service and numerically

constituted the largest group of nurses allocated to the general wards at City hospital.

Ward management styles and the nursing process

Wards where patient care scores on the questionnaire were high also had high section B scores (Ward Atmosphere/Staff Relations). Patients acknowledged the importance to their care of good ward atmospheres in which the sister was approachable both to themselves and students.

Questionnaire findings suggested that students perceived that a system of predominantly patient rather task allocation is in operation on the 12 medical wards in the sample. However, data yielded from patient interviews, participant and non-participant observation suggested that patients did not identify with individual nurses and that nurses worked in pairs rather than individually, looking after groups of patients. As discussed in chapter 6, and confirmed during non-participant observation, students were given the opportunity to change their allocated patients frequently. The most junior students were most likely to look after long term elderly patients on a continuous basis.

The accounts of students' investment in emotional labour, the types of 'sentimental work' that they did and whether it was recognised and acknowledged appear to support findings reported in chapter 6. Sisters made visible the patient care priorities valued on their ward in the way in which they controlled patient handovers and reports, emphasised physical, technical or affective care articulated through the practice of the nursing process and their own direct contact with patients.

The characteristics of the 'good' nurse, valued by patients, bore similarities to some of the characteristics of sisters and trained staff regarded by students as demonstrating favourable management styles (see chapter 6) towards both themselves and patients, i.e. being happy, cheerful and showing interest in others.

CHAPTER 8

STUDENTS AND THEIR WARD LEARNING

Introduction

In this chapter exploration of the ward learning environment continues, based on the findings presented in chapter 5 on the nature of nursing work and the learning material, and in chapter 6 on sisters' management styles.

In chapter 5, the nature of the work and the learning material, associated with ward specialty and characteristics of the patient population, were discussed. In this chapter additional experiences identified as valuable (or least valuable) to learning, as well as the processes by which students learn on the wards, are described. The interaction between students' needs and the ward learning environment is also explored. The maintenance of adequate staffing levels and mix for, and the input from nurse teachers to, ward teaching and learning are examined.

The relationship of ward management styles to the process of learning through caring is described in terms of the accessibility and approachability of trained staff to learners; the amount of contact provided by the way in which the work is organised between trained staff and students and senior and junior students in caring for patients together; the motivation of trained staff to teach and provide learning opportunities for students; and patients as teachers. The contribution of formal training requirements such as ward learning objectives, ward assessments and reports are also considered.

The findings are used to support the working hypothesis that: Sisters who are accessible and approachable are more likely to provide teaching and learning opportunities for students and meet their learning and emotional needs, rather than those who are not.

The findings are derived from: (a) interviews with students and tutors; (b) field observations and interviews from four study wards; and (c) self administered questionnaires on students' attitudes towards the ward learning environment.

The chapter contains four parts. The first part presents findings from interviews with students and tutors in order to explore how students learn on the wards and to identify factors which create the conditions for and militate against learning.

In the second part, four ward case studies are presented in order to demonstrate the complexity of the ward learning process. The case studies bring together data collected during participant observation, student interviews and questionnaire findings.

The third part examines questionnaire findings on the ward learning environment in relation to the ward learning process. The findings include item scores 1: 'This was a good ward for student learning'; 3: 'I learnt very much on this ward'; 7: 'The workload does not interfere with teaching and learning'; and section scores C and D: Ward teaching and Provision of learning opportunities. A number of relationships were tested between the mean scores presented in this and previous chapters. An analysis of responses to open-ended questions 37-41, which offer insights to teaching and learning processes on different wards, are also presented.

The final part of the chapter summarises the findings obtained from the different methods of data collection.

8.1 Interview Findings

During interviews, students' and nurse teachers' views on the ward teaching/learning process were explored. The people from whom and incidents from which students learnt were identified. The findings are grouped round the following issues which emerged as the research progressed: how students learn on the ward; the interaction between

students' needs and the ward learning environment; creating the conditions for learning: the structure of the ward learning environment, ward management styles and trained staff and inter-learner relationships; learning from patients; the role of formal training requirements in the ward learning process.

8.1.1 How students learn on the wards

As described in chapter 4, section 4.2.1 (p.156), the predominant teaching/learning paradigm referred to by students and tutors was one that presupposed that a formal teaching activity was necessary to ensure learning took place, in school or ward.

In terms of formal teaching on the wards, students were most likely to identify formal activities as tutorials, observing demonstrations of technical procedures performed by nurses and others, observing patients undergoing investigations and accompanying doctors on their rounds. Such activities were clearly described in the ward learning objective cards referred to in chapter 4, section 4.1.2(b) (p.150). Of these activities, tutorials were identified most frequently. Even though students believed that learning was more likely to take place on a ward if tutorials were arranged for them, a discussion with a group of third warders showed that they did not accept them uncritically. The students said that the tutorials needed to be organised at a time convenient to the ward; they should be geared to the students' level of training; the content should reflect the current patient population and take account of when the students were on duty. A difference of opinion ensued between those students who thought that ward tutorials might jeopardise patient care (the worker-learner dilemma):

When you go to a tutorial you think of all the things the patients need doing for them ... as nurses we should be giving patient care. You learn in the school.

This statement was met with protests from colleagues that the time spent in the school was infrequent, and that staff had responsibility

to teach, given that City was a teaching hospital.

Another student complained about one ward where the tutorials:

... were always so bitty, because in between you'd be getting up and doing the work. I thought they were next to useless, especially compared to Kinder, where one afternoon a week was allocated to teaching and however busy you were you'd still do it.

The following statements were common refrains from first year students:

A third year tutor gave a couple of tutorials but they have been so above my head that I haven't really understood any of it.

Doing two lots of nights meant I missed out on tutorials.

You can get the same topic three times over because someone may have asked for it who wasn't at the tutorial last time.

One third year student thought that sometimes first year students were given tutorials in preference to third year students, because the latter were more useful for doing the ward work. The student was referring to tutorials given by nurse teachers rather than ward staff. This may in part explain why first year students complained that the level of the tutorials given by the teachers was too advanced, since they were primarily intended for third year students.

Rarely, students mentioned ward tutorials which addressed the need to do emotional labour and its cost. Such an example was given by a third year student:

Yesterday we had a session up there (oncology ward) and it is very stressful because a lot of the patients are very young. And we had a session with one of the social workers and a tutor and all the students and it was very useful ... we can just say what we like ... and you can realise that it's not just you that feels like that (i.e. stressed); probably everyone is feeling the same.

Students gave examples of how their ward based assessments aided their learning:

I know if my aseptic technique hadn't been checked frequently I'd have got into very bad habits. Also the same with drug administration.

Another student who had thought she knew how to do aseptic dressing technique was shocked on her third ward when during her assessment she came close to being referred on a point of procedure. She concluded:

I learnt, but at great cost, and the effects it had on my confidence! It was a really negative way of learning.

A student about to take finals thought that each assessment helped to build up skills as part of a gradual learning process:

... you build up from aseptic technique to teaching and management responsibility. It's a general trend.

On further questioning and discussion, it became clear that students recognised that learning took place in other than formal ways. Both third and first year students told the researcher that 'you learn all the time without being taught'. The most common expressions used to describe the learning process were 'you pick it up' or 'it sinks in'. Thus, students recognised that informal learning was taking place whilst they were working on the ward. One third year student described ward learning in the following way:

For theory and practice to go together you've got to have learning in situ. You've got to learn as you do it and listen to ward reports, handovers, read kardexes and notes. Nobody will do it for you.

The importance to learning of the ward handover reports were expressed by another student:

I put down the afternoon reporting session as a teaching hour (on my ward objectives card) as it was such a rare event on that ward.

However another student added:

If it's normal (to have reporting sessions) it just becomes part of the ward routine.

The latter comment suggests that when the ward reporting session became part of the routine, it lost its value as a teaching tool.

When asked if using the nursing process helped ward learning, two third year students gave the following answers:

I learnt from doing the kardexes ... I was given insights into how to use the nursing process on Tarn Hows ward but I developed the writing of care plans myself.

When you've got time to go through it thoroughly I think everything falls into place - because a number of things you do, you haven't a clue why you are doing them. It's very good to make you sit down and think why am I doing this? perhaps I could do it better ... when

should I be doing it? I think it is a very good tool for learning, yes.

These comments confirm the findings in chapter 6, section 6.1.2, which suggest that the nursing process was linked in the students' eyes with record keeping and report writing for exchanging verbal and written information which could then be used to generate learning.

Students referred to 'doing things on your own' as another form of learning which was indirectly related to taking more responsibility as part of the process and product of gaining more confidence. The type of learning material generated by being on night duty, discussed in chapter 5, section 5.2.3(d), was a clear example of the interrelationships between 'doing things' on one's own, taking responsibility and becoming more confident. However, a third year student offered a caveat:

You don't learn by being thrown in at the deep end. I don't believe that shock treatment is therapeutic.

This quotation suggests the existence of a relationship between students' emotional and learning needs and is developed further in section 8.1.2 below.

It also emerged during the interviews that students felt that their ability to ask questions of the senior staff, in order to learn, increased as they took more responsibility and became more confident. The need to have sufficient confidence to ask questions could be seen as vital to the learning process. One third year, for example, illustrated this point when she said:

There is a lot to be said for the student when she is ready and when she needs knowledge, going forth and getting it.

As well as seeking knowledge from asking questions of the ward staff, students identified the use of textbooks for this purpose. For example, a third year student explained how she had been motivated to refer to textbooks to seek more knowledge on patients' conditions, not only because of her own interest in the ward specialty (oncology) but

also because of the interest shown by ward staff. A third year student also confirmed that, when the ward staff were interested both in students' learning as well as their own work, students felt encouraged to ask questions. In reply to the question 'how does your main learning take place?' a third warder in a discussion group replied:

Working, seeing the day-to-day (activities), the different sorts of illnesses, and how trained staff cope with them.

A third year said:

Just working together with other nurses, you just pick up little tips.

However, another student added an additional perspective:

On busy wards the care is too routinised. You don't learn. You do it (work), but you don't question.

The finding in chapter 4, section 4.3.2 (see p.184), that the majority of students thought that they learnt informally to communicate with patients (related to learning to do emotional labour) through role modelling and experience, is supported by additional findings on how students said they learnt on the wards.

First year students:

You saw sister or staff nurse in some very tricky situations with patients. They handled them so well. You just learnt by watching how they talked to them.

After just a few days on the ward a first warder identified that she had learnt:

... how the nurses sort of manage patients and talk to them and you just pick things up ... it's just their general attitude; you think 'that's a really nice way to treat someone' ... they show an example.

A third year student at the end of training held a similar view to the first year students:

I think you just learn by watching the way other people do things, like talking to the terminally ill.

Students also said that they learnt how not to communicate with patients (related to withholding emotional labour) from watching how

other health staff communicated with them. The following examples were given of poor communication: doctors speaking in medical terms and holding back information from patients; a medical student talking 'above' a patient. A first warder, during discussion, said:

You know immediately that's wrong, and from then on you're better at it yourself because you know what you should do.

The students frequently identified specific examples of poor communication between patients and non-nurses. They were more likely to identify examples of poor communication between themselves, trained staff and tutors rather than between nurses and patients.

In summary, students described a number of ways in which they learnt on the wards. The frequent reference to tutorials confirmed the predominance of the teaching/learning paradigm which presupposed formal teaching ensured learning. They also identified ward-based assessments of nursing skills as aids to learning. Students recognised that they learnt informally when working with and/or observing other nurses and participated in verbal and written handover reports. Self-confidence was described as an important aid to and outcome of learning.

8.1.2 The interaction between individual student needs and the ward learning environment

It emerged during interviews that, as students progressed through training, both their emotional and learning needs changed. These needs were associated with individual differences of life biography and stage of training and affected the way in which students experienced particular ward learning environments.

The findings demonstrate the interaction of student life biography and stage of training with ward environments and the effects on learning.

For example, a tutor articulated students' personal needs associated with life biography in the following way:

First years, it's all about support - a lot of home-sickness. They come away from home at 18 and they have to deal with Central London

... But the third years, they are two years on and they need support in terms of relationships and they are thinking about living out, so you have the problems of flats. And sometimes you get to the point where there are just so many different pressures on them that something is going to blow.

The tutor described some of these pressures:

It's either problems on the ward, problems with boy friends, plus problems in the home and it's all these things and 'state' coming.

She then identified the kinds of problems third year students experienced whilst working on the wards:

Oh, fantastic problems! They are third years and the expectations of the ward staff are sometimes beyond the students, so there is that. There is the need to be able to be in charge and to teach and to appear confident when you don't have any confidence ... they don't want to disappoint the juniors, but they are not given a lot of valuable support themselves because the ward staff think they are third years and should take responsibility.

Another tutor articulated the interaction of students' individual needs in relation to both the ward environment and stage of training in the following way:

Every ward operates in its own way. It's a culture shock ... Some wards encourage the students as individuals and others repress it. There is one ward they go to in their third year and they come out very frustrated and disgruntled because staff nurses do all the work of management. Other people go there and like it because they haven't reached the stage where they want to take responsibility ... so it varies with the individual as to what happens ... It's fascinating to see their reactions because you can have two people sitting there and you don't know they are talking about the same ward.

The tutor added that she thought that individual students reacted differently to the same ward because of:

... personality, expectations, grapevine ... and it depends as to whether the individual style (of a ward) suits them.

The tutors' observations are also supported by the following findings obtained from an analysis of data from student interviews.

For example, students at the end of their third year reflecting on their training said:

It took me six months to settle down. It was a great upheaval from home.

I don't think I learnt much in my first six months as I was frightened. I spent my first holiday worrying about going on nights.

I went through the first year thinking no-one else was scared ... I don't think you learn if you are frightened and I don't think I learnt much in my first six months and I don't remember a great deal about it ... I think it was because I was all tensed up, really.

Drawing on her own experience, the student went on to illustrate her point in the following way:

Like the first years at County Hospital (neighbouring teaching hospital where City students gained experience in working in an accident and emergency department) who are sent to Casualty: I'm not sure I taught them anything. They were lost ... They didn't learn anything because they were not at a decent stage to know enough to reap the benefits from it.

Other students talked about routines and procedures not 'making sense' early on in training. For example:

There are things (like the reasons behind taking four hourly observations) when you are a first year which don't necessarily make the same sense as they do when you are a third year.

By the time a student had reached her third ward she spoke for others when she said:

You just know more what's going on. You know more theory.

These statements are of interest in relation to the discussion in chapter 5, section 5.2.3 (p.230), on the specialism of the ward and stage of training. The inferences drawn from these statements suggest that stage of training rather than ward specialty had a bigger influence on shaping learning, because of its association with students' emotional needs, especially during the first ward experience.

The beginning of the third year was another period when stage of training could affect learning because of the emotional needs of some students. For example, one third year student at the time of her first interview (module 12) had been grappling with the decision whether to leave nursing or not:

When I went through the stage of being generally fed up and talked to my friends, you'd be amazed! Some of them said it before I did. But it always happens at a certain stage in the training -My tutor called it 'the blues time' during appraisal because, she said, 'It is recognised that people are disillusioned and fed up at this stage of nursing'.

The student told the researcher that she decided not to leave nursing:

... when I spoke to some of my friends and I found it's not just me, it's the place, it's the job; which is quite an exciting thing to discover.

Three other students also told the researcher during interview that they were close to leaving during the first few months of becoming a third year student. This finding supported the notion of 'blues time' described by the student above.

The beginning of the third year of training was a time of uncertainty for students because they returned to the general wards as senior students after a year of working in specialist wards where they were often supernumerary to the trained staff. The following statements convey the uncertainty experienced by students at that time:

Your first couple of wards as a third year, you're just settling in.

When you get your purple belt (denotes becoming a third year) people fail to realise the difference between someone just at the beginning of their third year or about to take 'state'.

In a later interview at the end of training the student who had referred to 'the blues time' talked about a personal tragedy in her life that had also contributed to her wanting to leave nursing. She described the interaction of life biography and stage of training on her emotional needs in the following way:

I nearly left, I think because I had so many negative things happening to me (including the death of her father), so many negative feelings about my work and my colleagues on the ward ... Do you remember I used to say was it happening just to me or was it happening to everybody?

The student interviewees quoted above were all direct entrants to nursing, and two of them felt that they would have been better able to cope with the demands of nurse training as mature entrants. As one student put it: 'I think you should be much more "worldly" before going into nursing.'

A tutor observed:

You see, I think most of the students within the school are bright, are capable and can actually survive ... that means that the one or two who are not so quick at picking up things ... actual knowledge-wise and actually picking up the routine of the ward ... and what

sister likes and doesn't like ... people who are not so quick at doing that, find it very very very difficult. And they can often be the most caring and sensitive people. Because they are ... they take it much more badly when somebody shouts at them or is cross. And I feel that if someone is sensitive and caring and is capable of nursing, then everything ought to be done to try and support them and help them so that they stay.

Students' reactions to the length of ward allocation (8 weeks) illustrate the interaction between individual and ward and add further perspectives on the tutor's comments on time taken to adapt to different ward routines. The following statement is a representative view held on the usual length of ward allocation:

8 weeks is long enough if you are hating the ward. if you are enjoying it you feel you are only just getting into the work.

Students throughout training continued to take an average of 2 weeks to 'get used' to a ward. One student at the beginning of her third year thought that 'adjustment' time had got less as she progressed through training:

When I was first starting it was taking me sometimes 3 or 4 weeks to get into the ward if there was a difficult staff relationship so I had 4 weeks to actually learn something. But I'm finding it much easier now to slip into the ward routine. On my last ward I felt quite relaxed after about 2 weeks.

A colleague in the same set said:

I'm a slow learner. The first few weeks you're picking up how the ward works. You're not perhaps learning, you tend to learn more in the last 3 weeks. You begin to feel that you have found your feet.

A first warder observed a finalist on Kinder ward who had been keen to teach her:

In the first 2 weeks she was really down and I thought 'Oh dear!' But she says it takes her 2 weeks to settle in and then she really changed.

A third year student concluded:

I don't know if anyone really appreciates how anxious you are starting a new ward.

These findings demonstrate the demands on students to learn at the same time as manage complex feelings as soon as they begin training, usually at the youthful age of 18 and again during 'blues time' at the

beginning of the third year.

The findings also suggest that starting on a new ward is a relatively anxious time for the student throughout training and demands a period of adaptation to each learning environment. These findings confirm Revans' (1964) statement that students are faced with a considerable task of adjustment to a way of life (p.54) and those reported by Birch (1975) in a study that identified anxiety as an important influence on students' withdrawal from training.

Overall, the findings show that students' perceptions of the ward learning environment were influenced by their personal and learning needs at different stages of their training.

8.1.3 Creating the conditions for learning

(a) The structure of the ward learning environment

It was established in chapter 5 that students were the main workforce and that their learning needs were secondary to staffing the hospital. Consequently, students identified their ward activities as work rather than learning material, especially if staffing levels were low in comparison to the workload. In the ward case studies presented in chapter 6, sections 6.2.1(c) - 6.2.4(c), it was shown that because of the way in which the ward work was organised students either worked alone in caring for patients or with other students. Direct contact with trained staff in caring for patients together was infrequent. Third year students expected to supervise more junior students, rather than be supervised themselves. Findings presented in chapter 7 confirmed these patterns of work organisation.

The importance of providing the structure for teaching/learning on a ward in terms of adequate staffing levels, trained staff and student ratios and maintaining quality of nursing is illustrated by the following quotations.

A tutor told the researcher during interview that:

I don't believe there should be this dichotomy or this conflict between education and service because basically the needs of the patient and the students are the same.

The tutor rationalised this statement as follows:

A situation in a ward which is poor from a patient's point of view is understaffed. It is also a poor learning situation for the learner because she sees people taking short cuts. She sees things not being done and she gets frustrated because what she believes should be done is not being done ... or it may simply be a question of numbers of staff nurses or sister who are available to actually work with them.

Two third year students confirmed the tutor's views and gave examples, grounded in recent experience, of inadequate structure for the provision of teaching/learning and the maintenance of quality of nursing on a ward.

At the moment, it's all we can do to get the work done. It's quite normal on an average shift for a second warder to have six patients under her total control on her own. And it's her first surgical ward ... the staff nurse is totally preoccupied with management and as a third year ... I can't sort of give myself time to keep an eye on her because I've got 15 patients. (Third year student)

Another third year student observed the reluctance of juniors to ask third year students and trained staff questions about patient care because they appeared 'busy'. She thought that it depended to some extent on the staffing levels:

If they (the staffing levels) are low then they (the trained staff) just haven't got time to see what other people are doing and they expect you (the student) to just go and grab them if you want help. And that's not really a reflection on the trained staff.

That the first-third year student mix might make a difference to ward learning conditions was reflected in a third year student's observation that she preferred it when there were more third year students on a ward so that 'there's not so much running around to do after the first years'.

During two separate discussions, first year students noted the need for clinical teaching from the school to supplement low staffing levels and high workload on the wards. Students at the end of their second ward allocation:

I think we should have clinical teachers. We are students on the wards and we're just flung in at the deep end.

You're expected to know such a lot.

Some people didn't seem to realise that we are new.

Students at the end of their third ward allocation:

On the last ward I was doing a drug assessment. I worked with the clinical teacher. She came up and did a drug round with me. On a busy ward the staff haven't got time.

In one case of low staffing levels on a busy surgical ward, a third year student told the researcher that clinical teaching from the school was sought by the senior staff nurse. The student described how the staff nurse rang up the Assistant Director of Nurse Education (ADNE) in the school of nursing to say that she was having difficulties supporting the students. A tutor was commissioned to go and work on the ward during the periods of short staffing. This type of request was infrequent and attributed by the third year student to a staff nurse who was 'incredibly sensitive to your needs' and used 'her initiative'.

Students, particularly at the beginning of training, frequently identified their teachers' potential contribution to ward teaching. It was noted in chapter 4, section 4.2.1 (p.156), for example, that at the beginning of their learning trajectory students felt positively towards their classroom based activities. This was also the case in terms of them wanting to see their teachers on the wards, as illustrated by the comments of three first warders:

I thought the teachers came and worked with us. I think they should. I don't think it's the staff nurse's role ... If you had a more formal teaching input you could really know the correct way.

I saw Mrs J once. She came to say that she was the tutor for the ward (cardiology) and would like to come and work with me. But I never saw her there. You feel you'd like to tell them what you've done, what they taught you, to connect it, like the cardiovascular system, which we learnt about in class.

I thought someone (from the school) was going to come on Wednesdays to give tutorials, so I was always waiting. I think it would be helpful to have contact with the people you'd been with at the beginning. Even if they just came up and said 'Are you doing all right?'.

A discussion with a group of students who had just completed their third module showed that they considered the teacher's presence on the ward as important for the following reasons:

On your first and second ward it's good to know how you're forming up and to ask her (the teacher) to sit down and give you feedback on your morning's work. And she says 'This is your good point and this is your weak point' ... It's a really good confidence booster. You really need that.

When I was on the last ward and doing a drug assessment, I worked with the clinical teacher. She came up and did a drug round with me and taught about the drugs and how you should do it (the round).

It also emerged that many third year students reacted negatively and defensively to having teachers working with them. For example, a third warder described the reactions of third year students in the following way:

The third years, they don't need the clinical teachers. They say that they don't want it. They can't think of anything worse. They think it's humiliating as well as everything else to have someone looking over you.

One third year student, speaking on behalf of her peers, was more positive about the contribution of tutorial staff to ward learning. She said:

I think most third years would say they would like a bit more guidance in the academic field ... If there was a tutor on the ward I would try and consolidate my knowledge and they could guide you a bit more. You are in school very rarely. The staff nurses don't have the time.

Thus, the tutorial staff were regarded as having primary responsibility for nurse training, because students associated them with formal knowledge and teaching whilst the trained staff's first commitment was to patient care. Why then were students critical of nurse teachers?

In the case of the first warders who had expected their teachers on the ward, they had been disappointed by their non-appearance. Positive attitudes towards the school and their teachers consequently turned sour. Sour attitudes were reinforced by negative reactions shown by third years towards the teachers.

Additional evidence showed that students became increasingly

critical of teachers because their approach to patient care was seen as unrealistic and/or impractical. Students criticised the time taken by teachers to care for patients:

On my second ward she (the teacher) came up and we spent two hours doing a bed bath. (Student in her third module)

Sometimes ward staff were said to sow the seeds of criticism in the students' minds, as the following comment illustrates:

I had two mornings with the clinical teacher. It was straight out of the book. Sister said to me 'You won't get any work done this morning'. (Student at the end of her first ward allocation)

Some teachers were charged with putting unrealistic demands on the students in terms of the content of patient care. A student in her third module described an incident with her teacher during her second ward allocation. The teacher was reported to have 'ticked off' the student and said:

'Do you realise where you went wrong?' It was an afternoon and I was taking someone to the garden. I said 'no'. She said: 'You've got to see your faults, that's the whole idea'. I said 'Yes, I realise that, but if you could tell me ...' She said: 'You've got to consider the patient; you didn't stop at the (hospital) shop to ask them if they wanted something to eat in the garden'.

A possible explanation for what were experienced by students as their teachers' unrealistic demands might lie in the way in which the latter went to the wards for only short periods of time (2-3 hours). The researcher noted the difference between working in this way as a former nurse teacher and for whole shifts as a participant observer. The understanding of and involvement with the ward was at a much deeper level than the three-hour fragments as a teacher, and gave one more confidence and knowledge to offer a more realistic approach to patient care within the specific ward context. During interview, a student on her fourth ward confirmed the importance of ongoing contact between teachers and ward in order to teach more effectively:

The tutors don't know what's going on in the ward. You've got to be in the ward environment; do lates, days and nights to be really on the ward. Not just on Monday afternoons, for example.

As established in chapter 4, section 4.2.1 (see p.158), nurse teachers were associated with the formal teaching of nursing in school and ward, rather than working practically with the students. They frankly admitted that they did not have time to work with the students on the wards, because of the demands of classroom teaching. The following quotation is representative of how many tutors felt about their contact with the wards:

I will be absolutely honest. In theory I support ward liaison, marvellous! You know that if one is to be credible as a nurse teacher one has got to be seen to be able to function in a clinical area with all its difficulties and constraints. Having said that, I am finding it extremely difficult to achieve, in terms of time. It's making me feel guilty and dissatisfied with the way I am performing my job, because I feel it should be done, but I am not able to achieve it. And because the contact is spasmodic I am usually there under duress, when really you have other things to be doing. You can't relax and enjoy the period of time that you have spent on the wards, so wherever possible one tends to avoid it.

In summary, the findings demonstrate that the balance between ward staffing levels, mix and workload must be maintained at a minimal level to provide the conditions for learning and maintain quality of nursing on the wards. Clinical teaching, as an important resource in creating ward learning conditions and the primary responsibility of tutorial staff for establishing and maintaining contact with students on the wards throughout training, were also identified. Adequate staffing levels were also required in the school of nursing to release teachers from the constant demands of classroom teaching in order to give them the opportunity to work practically and realistically with students and patients on the wards. The need for nurse teachers to teach from 'the real situation of the ward' rather than 'imparting knowledge from the classroom', as recommended by Bendall (1975) and Gott (1984), was recognised by teachers, students and trained nurses at the City hospital. However, the structural changes necessary to implement such a change were not in evidence. The potential of the school and nurse teachers for student learning identified by students and trained staff

goes beyond Dodd's (1973) findings that students regarded them as irrelevant to the real situation of the ward.

(b) Ward management styles

Research findings presented in chapter 5 demonstrated that the nature of the nursing work was also the student's learning material; that they saw their activities on the ward primarily as work and themselves as workers; but that they recognised their notional student status and their need to learn.

It was then shown in chapter 6 that sisters' management styles, indicated by ward atmospheres, staff relations, and the use of the nursing process to organise and prioritise care, were intimately related to quality of nursing and ward learning. The relationship of these indicators to the provision of teaching/learning opportunities and meeting students' emotional needs on the ward are examined in more detail here.

The following interview data represent general statements on ward conditions associated with management styles that were identified as important for learning. A tutor said:

I think an 'ideal' learning environment is one where there is total consistency, where there is teamwork in all its aspects, and you don't have a hierarchical 'us and them' situation; where it's seen to be fair and consistent and sister and staff nurse roll up their sleeves and work. Because if you accept that most of the learning is unconscious, then I think one has to accept that the qualified nurses are the role models working with students.

Another tutor identified two surgical wards where the sisters:

... create an efficient and effective environment ... and (are) regarded with respect and affection by the nurses. The atmosphere on their wards is 'very safe'. They are quite imposing looking and yet they are extremely approachable. They are very clear cut in what they want and the students know where they are.

These statements supported findings presented in chapter 6, section 6.1.1, that approachable, accessible and consistent ward management styles were important in the creation of a positive atmosphere in which students felt they could learn. A third year student at the end of

training identified 'ward atmosphere' as more important than the nature of the work to 'enjoyment', which in turn she associated with learning and maintaining quality of nursing:

Actual enjoyment isn't related to the sort of nursing you are doing. It's much more what the atmosphere on the ward is like and who you are working with and how ill your patients are ... I think where there is a lot of input from ward staff and they want to teach you, you get a lot more from it and you're happier about nursing the patients because you've got more information.

Another third year student, the only male interviewee, described a good learning ward as one 'with a relaxed atmosphere when you can ask questions about why you are doing things and you feel you've a role to play'. He went on to conclude:

Fear isn't a good way to learn; respect is the best. If you feel appreciated you try to live up to the faith people have in you. It's a very strong stimulus.

Findings also showed that although the ward sister was important to the creation of the ward learning environment, she was rarely identified as the person from whom the students learnt directly. A third year student, for example, said:

I am sure the only way you learn is from a nurse you admire.

Another third year student at the end of training told the researcher that:

On each ward there is someone who stands out nursing-wise, who you could relate to. Each ward it's different; it could be the sister, the ward staff or the third years.

Another student assessed the importance of the sister to ward learning in the following way:

I don't think sister is the most important person to ward learning. I think anybody - trained staff, anybody that's got the information. I think obviously sisters are important but I mean I think junior staff nurses are too ... I think if sister is interested probably it reflects on the staff nurses and so they become interested and they come and teach as well.

A discussion with third warders yielded similar and additional insights:

S. You can't expect the sisters to teach because they've got the ward management and everything, or the staff nurses, really. It's

got to come from the school.

S. But that's part of their (ward staff) job!

S. Yes, but on a busy ward ...

S. Yes, but that post is teaching whether it's sitting down or actually working with students.

S. A lot of the staff nurses are newly qualified so they should be aware of our needs.

S. They're very much under sister. They were on my last ward. Sister rules the roost and if she wants teaching to take place on the ward then staff nurses will comply with that, but if she doesn't, she wants jobs got on with, then it won't happen.

A tutor confirmed the views expressed in this discussion when she reported that:

Students don't feel that the staff nurses and sisters supervise. A lot of them say the 'trained staff sit in the office all day and we have to get on with it'.

Other students also described similar situations on the wards:

The more trained staff there are on a shift the less teaching and support you get. (Third year student)

The ward wasn't very busy but the staff still couldn't find the time to teach. They were chatting with the doctors in the office. (Third warder talking about her last ward allocation.)

As established in chapter 6, section 6.1.1, students appreciated seeing the trained staff out on the ward working alongside them even if they were not actually working directly with them. The following statement, already used to describe management styles in chapter 6, also illustrates that the staff being out on the ward meant that they were seen to be supportive:

You feel supported on the ward if you see the sister a lot - not just sitting in the office sending the orders down. (Third year student)

The same student also thought that it was important that the trained staff:

... take an interest in how you are feeling about the ward. Some people think of this and make sure that the work is allocated fairly and within your capabilities ... but saying 'I'll come and help you' if you haven't done it before and wanting you to further your knowledge and experience.

Key management characteristics which created the conditions for learning to take place as illustrated by the preceding accounts included: approachable and accessible trained staff, especially the sisters who set the tone and created a relaxed, friendly, safe, atmosphere, were consistent in the expectations they had for students, were motivated to teach and give information about patient care, and appreciated their individual needs. As discussed in chapter 6, section 6.1.1, these characteristics were also shown to be closely associated by students and tutors with maintaining the quality of nursing.

(c) Trained staff and interlearner relationships

The implications for ward learning of work organisation and contact between different grades of staff, as described in chapter 6, sections 6.2.1(c) - 6.2.4(c), and section 8.1.3(a) above, in terms of people other than the sister from whom students learnt, are explored in more detail below.

During interview and participant observation, it emerged that the people from whom the students directly learnt related to the hierarchical way in which nursing was organised. In their studies of ward learning Fretwell (1982), confirmed by Reid (1983), also found that students were more likely to work with other students because of the way 'in which tasks are allocated to workers according to a place in the hierarchy'. Consequently, this system 'takes trained nurses away from learners who are most in need of help' (p.112). On the medical wards at City hospital, there was a mix of trained staff (sister and/or staff nurse(s)) and third year (from module 12 to 15), one second year on a short allocation and first year (first and third module) students. Ward profiles (chapter 5) and QualPacs observations in chapter 7 give a flavour of the variability in staffing mix and workload on different shifts in the four study wards.

The shift system was identified as one factor which influenced the

content of students' learning and the people from whom they learnt, as the following statements suggest.

One first warder during interview insisted that she learnt from everybody including her colleague in the same set because:

We're on different shifts and for varying numbers of days at a time, so we vary as to what we know and according to the different things we've seen and done.

A third year student commented that:

Who you work with (and by inference who you might learn from) depends on the shifts you are on. It means you may never meet up with sister.

Internal rotation to night duty was being introduced to wards at City hospital during the study period, which meant that many students had the opportunity for one to one contact with a staff nurse during the night. First year students especially said that they found this close and continuous contact (up to seven nights) helpful for their learning. Not only did they tell the researcher that they could get to know the staff nurse as a 'person' but also that she was able to give them both formal knowledge and practical supervision.

It was observed by the researcher that the shift system tended to fragment the amount of continuous contact that trained and student nurses had between each other and the sister was no exception, as the third year student's comment illustrates above.

As discussed in chapter 6 and 7, third year students were the hub of the nursing service both in terms of nursing patients and supervising first year students. The students' shift of focus during the three year training, from patient to medical, technical, management and teaching activities, was noted in chapter 5.

Findings relating to the role of third year students in the ward learning environment are presented below. It emerged that third year students made an important contribution in meeting other students' learning and emotional needs, sometimes at the cost of their own needs,

as the following comments suggest.

One first year student described third year students as a 'mother figure'. Another student who was in her third year said that she felt protective towards the first year students. Yet another third year student said that she thought that:

... the third years aren't quite so detached as trained staff. You feel more like they (first years) do.

A third year student looking back to the beginning of training commented:

It's difficult when you're a first year because you're frightened to ask someone senior who seems totally unapproachable.

Current first year students also said that on the whole they found third year students more approachable than trained staff. During group discussion with first year students, one participant expressed a common view when she said:

I've learnt the most working with a third year who is prepared to sort of work as you go along ... and you can then mention what you didn't understand in report.

A third year student articulated her teaching responsibilities to first year students in the following way:

I feel that if you are working as a pair you can organise your work so that you can look after the patient together and you can show her how to do things and she can help you take out stitches and if you are bathing a rather heavy patient ... doing things together they (first years) just learn naturally.

In terms of formal learning first year students also identified third year students as their ward teachers:

The third year students teach you when they are coming up to 'state', related to what they are revising.

During a group discussion with first and third year students, the former expressed disbelief that their senior colleagues 'did not know everything there is to know about a ward'. However, there was also a recognition on the part of first year students that their colleagues in the third year were still students. Learning from them could not always be guaranteed, therefore, to be 'the right way'.

Third year students also told the researcher that they experienced inconsistencies in their role, particularly in relation to swings of responsibility, described by one student in the following way:

One minute you're in charge; the next minute they're (trained staff) asking you if you know how to take a CSU (catheter specimen of urine).

One third year student described her role in terms of meeting emotional needs:

Third years support first years on some wards but everyone needs it as well as reassurance. The third years get cross at not getting support.

Another third year student said:

On my last ward (oncology) a lot of psychological support was given to first years. Third years were expected to cope.

First year students confirmed that they felt relatively well supported in their first ward. However, by the time she reached her third ward allocation, one student observed: 'You don't get so much attention', whereas another third warder who had just finished her allocation to Windermere ward said:

That depends on your ward because we got as much attention. Everyone, thirds to first years.

The hierarchical nature of the relationships among nurses was reflected in the following statements:

There is a change over three years. You look up to people all the time and suddenly there isn't anybody there anymore. You've suddenly got to make decisions.

Another student viewed the change over three years as more gradual:

In the first year you don't think you will have the confidence and be supportive and help and teach other students, but you build up to teaching and management responsibility through your assessments ... and you learn through other students to stick up for yourself.

The negative connotations of being at the bottom of the hierarchy were expressed by a third warder:

It's strange that first week (third ward) when you've actually got someone turning round and asking you something ... you're not quite the bottom of the dirtpile any more.

The second year of training was viewed as a reprieve from hierarchical

relationships by two students:

In the second year you're working with your own set or set below, so you can organise each other.

Another student felt that the advantage of working together with peers in the second year was that 'you could discuss things together'. It could be inferred that the reprieve from hierarchical relationships facilitated peer group learning.

Two third year students recognised that they learnt from students in their first year. As described in the ward case studies presented in chapters 6 and 7, first year students were frequently found to be more involved in undertaking direct emotional labour with patients than more senior students. It was the freshness, enquiry and perceived communication with patients, i.e. the emotional aspects of the first year students' labour, that the third year students identified as valuable to their learning. One of the third year students is quoted twice from two separate interviews.

Too often we just, well ... we get into the rut of doing something ... and we just continue to do it because it has to be done and that's the way. Then you get the first years and they are not so rushed and stressed as you are, they don't have the responsibility and they ask 'why is that done like that?'

The student also said that she appreciated the first year students' questions because it made her stop and think what she was doing. In a previous interview she observed:

I am sure when you are on your first ward you have an uncanny way of getting to know your patients, which you seem to lose. You don't know half the technology which is going on around you. You are unaware of the necessity for speed to get all the jobs done. I used to often get shouted at, well sort of reminded that I have umpteen things to do when I was sitting there talking to patients.

A student in the same set and at the same stage of training at the time of interview said:

First years are so good to have around the wards. I think nurses do tend to get a bit more cynical as they get more used to the job, as they feel more at home. So it is good to have someone more fresh. They are very good at talking to the patients and take a lot of time, perhaps because they are not so aware of what is to be done.

However, a tutor recounted a teaching session with another set of third year students which demonstrated that although students in their first year were perceived as being more likely to communicate verbally with patients, they were not always able to respond adequately to the patients' needs because of their inexperience and lack of supervision:

A student described an incident where this patient was vomiting and therefore not able to go home. And the first ward nurse simply couldn't cope with that. All she could say was 'It'll be all right, it'll be all right ...'

The above accounts demonstrate that the shift system, staffing mix and the strong hierarchical relationships within nursing rather than personal styles of management alone appeared to determine the people from whom students were able to learn. Hence the most inexperienced students were more likely to learn from students who were only relatively more experienced than themselves, as described by Fretwell (1982).

The inexperience of the majority of nurses who worked together was described by a finalist, a mature entrant to nursing:

I was very struck with what I learnt on Casualty at County Hospital. The staff nurses were really quite experienced and had been in nursing between 8 and 9 years. The difference is very noticeable between them and the newly qualified staff and the majority of nurses working on the wards at City who are relative beginners.

This same student, whose father was an accountant, concluded:

Whilst my father was practising, he noticed the change round between having articled clerks and more recently university graduates coming into the profession. And no matter how perfect their theory was ... it was actually a case of always coming back and working with a trained accountant. I do think that we learn very much in that way.

However, as was apparent from the findings presented above, students rarely worked with trained nurses on a systematic basis.

Melia (1984) also found that students were more likely to spend time working with untrained nurses which, in her view, cast serious doubt on nursing as a 'true' apprenticeship.

The complexity of joint working-learning relationships which also

involved emotional labour was expressed graphically by a third year student:

In nursing, you have got so many relationships to form with people who you have never met before, who you probably don't like, you may not like out of work, under circumstances which are tremendously difficult. Often the relationships are short and sharp with hierarchy and authority and discipline somewhere mixed up into them, the learning situation as well. And the student who is trying to gain knowledge from this person, who she is trying to form a relationship with, when you add all that together, well I think you are bound to have chaos and I think you do have chaos. And so I think that in the nursing world as a whole everybody moulds everybody else.

In summary, the above accounts about students and their ward learning suggest that students learn to nurse through contact with nurses in general and student nurses in particular.

Students were identified as important to ward learning because they were seen to be more approachable and accessible than some sisters and trained staff who were described as distant and distinct. The students' perceptions of the trained staff were also shaped by their respective positions in the nursing hierarchy. Thus, students' working and learning relationships were fragmented by both the nursing hierarchy but also by the shift system.

The affective elements of nursing and the need to do emotional labour were described in chapters 6 and 7. Inferences of relevance to the discussion on ward learning, and the people from whom students learnt, were also made from findings which suggested that the first year students were more likely to do direct emotional labour with patients. Third year students said that they learnt from first year students because of the latter's involvement in direct emotional labour with patients.

However, the quality of that emotional labour and its cost was questionable in the absence of systematised, supervised care which recognised emotional labour and made it 'intelligible' to the student.

Third year students did emotional labour on behalf of first year

students - they protected them, acted as their 'mother figure' and felt responsible for them. They also felt responsible for getting the work done on the ward on behalf of the trained staff.

Going through a 'blues time' at the beginning of the third year (section 8.1.2 above) might be interpreted as one of the consequences of doing unsupported emotional labour.

8.1.4 Learning from patients

Students said that they learnt from patients as well as from other nurses. The quotations below illustrate that students identified two ways of learning from them. Firstly they learnt about the factual and technical aspects of patient care and secondly about how patients felt and/or reacted to their condition. For example, one third warder who had been on an oncology ward said:

You learn from patients. If you actually went up to somebody and just chatted, they'd tell you what they knew about themselves, like their signs and symptoms.

About patients' feelings a first warder observed:

On a cancer ward, you learnt a lot about what patients didn't say. A third year student reflecting on the people she had learnt from during training commented:

You learn from patients. They know a lot about their diseases. Other students gave examples of doing dressings and seeking information from patients on how to do them.

Two third year students gave insights on learning about patients' feelings from two perspectives. From the first student's statement it might be inferred that she learnt about managing her own feelings in relation to patients and found it 'easier' to adapt to people she liked:

You learn from the patients and you adapt to their different characters, especially the patients you like the best.

The second student learnt about the patient's feelings:

You learn from patients about how they actually feel about what's

wrong with them. It is very hard to appreciate how much things hurt unless you talk to the patient.

Similarly a first warder observed, following a school session on patient perception :

It's good to stop and think about how people feel, otherwise you treat them like objects ... you never stop and think, like if I were going for an operation I'd be really worried.

In summary, the students appeared to learn primarily about the affective elements of nursing from patients and how to do emotional labour.

8.1.5 Formal training requirements and the ward learning process

(a) Assessments and ward reports

Assessments and ward reports described in chapter 4, section 4.1.2(b) were the most common channel of feedback that students received on their performance. Their relevance for learning how to do emotional labour was discussed in chapter 4, section 4.3.3 (p.186). As was shown in section 8.1.1 on how students learn, ward based assessments were identified as a way of learning.

One reason that students said they felt cautious in their relationships with trained ward staff was that they were aware that they were the people who assessed them through formal assessments and ward reports. As one tutor observed:

A problem may arise on the ward and the student might get unhappy but they won't say anything to the ward staff because they are frightened of the ward reports.

The finding that students identified favourable ward learning environments with staff who were approachable, accessible and consistent (section 8.1.3(b)) is relevant to a discussion of ward assessments and reports. When staff were consistent, students had a sense of what was expected of them, both during assessments and at other times on the ward. Otherwise, the role of the trained staff as the students' assessors served to reinforce the hierarchical nature of their relationship. It was noted in chapter 6, section 6.3.3(a), for

example, that the way in which trained staff handled students' ward reports was identified as a common cause of anxiety and stress.

As demonstrated by the ward case studies in section 8.2 below, feedback other than assessments on how students were performing was rare. Often the halfway report was used as an opportunity to give feedback after 4 weeks on the ward, rather than continuously on a shift or weekly basis. Students were often told without warning of any shortcomings in their performance as perceived by the trained staff. Students were more likely to get negative feedback rather than positive encouragement.

The findings confirm those reported in chapter 4, section 4.3.3 (p.186), that the association of negative feedback with ward based assessments and reports served as an indirect means of supervising students to do emotional labour.

(b) The ward learning objectives

The content of the ward learning objectives were discussed in chapter 4, section 4.1.2(b) (p.150). However, interview findings suggested that the objectives played a minimal role in students' learning except at the beginning of training. First year students gave examples of staff nurses using the ward objectives as the basis of teaching sessions. The ward objective cards had to be filled in prior to taking ward based assessments. There was no distinction made on the cards between ward objectives relevant to first and third year students.

A third warder described the ward objectives in the following way:

They're good if the ward uses them. Often they (the trained staff) do them on your last day, but it's up to you to badger them.

Third year student, end of training:

I think they (the objectives) come after the wards. You get to know the wards and what happens there and you get teaching and then you turn to the cards.

Two other third year students were more negative about using the objectives as a framework for teaching:

At the beginning of the first year when I took my objective card to the school no-one looked at it, so certainly I didn't continue taking them in my second and third year.

In the third year you find that you don't really need them for 'state' and then you feel a bit let down, in a way ... and then you don't bother after that ... And I think the ward tends to look upon them as the sort of thing you lose ... I think they could be quite good if they were actually used.

In summary, there was little evidence to suggest from the interview data that the ward objectives served any learning function. Students regarded them as a bureaucratic chore rather than as a learning tool.

8.2 The Teaching and Learning Process on Four Wards

Four case studies provide additional findings to those presented in section 8.1 on the ward teaching/learning process. The studies build on findings presented in chapters 5 and 6 on the nature of the work and the learning material and sisters' management styles. These findings are derived from participant observation, student questionnaire comments and interviews with ward sisters and students. Each study is divided into three sections. The first section describes the ward sister's views on the teaching and learning of nursing as stated during interview. The second section describes the formal and informal ways in which students learnt on the ward and from whom. The final section examines the role of formal training requirements (i.e. assessments, ward objectives and reports) in the teaching/learning process.

The findings presented in the ward case studies are used as evidence to support the working hypothesis that: Sisters who are accessible and approachable are more likely to provide teaching and learning opportunities for students and meet their learning and emotional needs, rather than those who are not.

8.2.1 Edale ward

(a) The ward sister's views of teaching and learning nursing

During interview, Sister Edale said there was 'not a very strong link' between school and ward and that the tutor liaison system existed in name only. A clinical teacher came to work with the first year students but in the sister's view she did not concentrate 'on the practical things' such as making sure that the students were achieving their ward learning objectives. She also said that in her experience, third year students only worked with the clinical teacher, if they failed their ward based assessments. She disagreed with this policy and thought that it should be routine for students to work with clinical teachers at any stage of their training to give feedback on their performance.

The sister said that in general, the first year students were motivated to learn and made good progress whilst they were on the ward. Many third year students were less motivated, and as a result 'don't get anywhere'. As mentioned in chapter 6, sections 6.2.1(b) and (c), the sister was aware that there was a feeling amongst third year students on Edale ward that 'we don't give them enough responsibility as we allocate them patients but don't leave them in charge'.

The sister felt that there was a need for a ward based 'junior sister' with responsibility for monitoring each student allocated to the ward, in order to ensure that she was fulfilling her learning needs.

The sister commented favourably on the way in which a former clinical teacher had worked on Edale ward. The teacher was described as someone who would 'roll her sleeves up; teach anyone, including the staff nurses, and organise ward tutorials'. The sister added that in her view, the only way in which 'to get anywhere' as a clinical teacher was through an ongoing relationship with ward staff and involvement in

patient care.

The sister's past activities in the school included teaching about diabetes and membership of an education committee.

The sister said that although ward tutorials were planned, they did not take place if the ward was busy. One afternoon when the researcher was on the ward, a house officer volunteered to teach the students. The sister declined his offer, saying that the ward was too busy, and confirmed that patient care took priority over tutorials.

When the sister was asked how she found out what the nurses were doing, she said she went 'behind the curtains a lot' and that she formed an impression of each student's capabilities which would determine how much contact she would have with them. The sister said that she would like to give more time to 'counselling of students and following through their work'.

(b) Students' formal and informal learning

Informal discussions and observations on the ward yielded additional information to the interview with the sister, on the student learning environment. There were few formal teaching sessions on Edale ward during the period of participant observation. The sister preferred to use the afternoon handover as a teaching report.

When tutorials were given, they followed the ward handover report. The researcher attended two tutorials during her time on Edale ward. It was noted that medical topics were usually selected for the tutorials, such as diabetes, strokes and heart failure.

Students were unanimous that Sister Edale was committed to teaching students and would always find the time to fulfil this commitment. Not only was she described by students as giving tutorials, but also as using the ward report and drug rounds for teaching purposes. The staff nurses were also described as taking their teaching responsibilities seriously.

As described in chapter 6, Sister Edale's management style was not always popular with students. She was frequently described as 'strict'. However, her 'strict' style was associated with 'doing things properly'. Her emphasis on teaching was also viewed by students as 'doing things the correct way' and 'not learning bad habits'.

The researcher observed that the clinical teacher's presence on the ward was unsystematic and lacked continuity with both patients and students. She came to work with first year students for short periods of time and did not always keep her appointments. One first warder confirmed the researcher's observation when she said:

I don't think the tutor gave us much support ... she helped me do a hoist bath or something but she didn't know the patients and she tried to pretend she knew me but she can't know me really ... I don't see how she can assess your work after just an hour and a half or whatever.

The clinical teacher left the City school of nursing soon after the participant observation period was completed, and was not replaced.

It was shown in chapter 6, sections 6.2.1(b) and (c), and section 8.2.1(a) above, that third year students on Edale ward complained that they were not given enough responsibility and resented being supervised by the trained staff.

First year students, however, maintained that third year students, rather than the trained staff, played an important role in teaching and supervising them. One first warder said:

I think the staff nurses recognise the good third years, because F was the one I was put with mostly.

She described F (a finalist) as:

... excellent. She was really helpful and she's a brilliant teacher and she knows how we feel.

It was also shown in chapter 6, section 6.2.1(b) that third year students described the staff nurses as 'very anxious' because of the high standards set by the sister. It is likely that anxiety made the staff nurses turn to the third year students for support. For example,

Staff nurse R told the researcher that one of the third year students was very supportive to her and 'never minded what she did'.

The qualities valued by trained and student nurses illustrate the importance of third year students in providing emotional support to others. For two first warders, 'there are certain third years you can always go to ... they treat you as equal because you are new'. Junior students valued any nurse senior to themselves who 'knows how we feel' and 'puts herself in your shoes'. A first warder might sometimes prefer to seek information from a third warder because 'she can remember really clearly how she felt on her first ward because it wasn't that long ago'. The third year student K, who was described in chapter 6, section 6.2.1(b) as feeling stressed and demoralised by Sister Edale's management style, was able to 'battle through' because 'I became friends with the other students on the ward and we got on well and we were lots of support for each other'.

(c) The role of formal training requirements in the teaching/learning process

It emerged that one of the reasons that the sister generated stress and anxiety was that she took student assessments and ward reports seriously. During participant observation, she once stopped a first warder's assessment on discovering that the student's ward learning objectives had not been signed. Students were expected to have their objective cards signed by a trained nurse to verify that they had been achieved, before taking their assessments. Most assessors did not insist on the objectives being signed before assessing students. However, Sister Edale, in keeping with her reputation of 'doing things by the book' would not assess a student if her objective card had not been signed. She also told the researcher that many ward sisters were 'afraid to put their money where their mouth is' and did not use student assessment to pick up problems early in training. Consequently these problems only became apparent in the third year when it was too

late to correct them.

In the sister's experience, third year students were resentful when criticised. She gave the example of a third year student who thought she was progressing satisfactorily during her allocation to another ward. On the day before she left the ward she was surprised to receive a bad report. According to Sister Edale, this was quite usual. Few students said they had the opportunity to discuss their reports in a meaningful way with trained staff.

On Edale ward, students were usually given feedback after four weeks on the ward and at the end of their allocation. The sister spent time with them discussing their final report. She also involved the staff nurses in preparing students for drug and management assessments. Feedback was always given after the assessments had been completed.

The sister's philosophy on assessment and feedback produced varying reactions from the students. For example, a third year student was described as 'tearful' when trained staff told her they did not think she was doing as well on the ward as she thought she was. She was described among the staff as 'showing no initiative and wandering around in circles as if she did not know what she was doing'. They reflected that perhaps her forthcoming finals might be having an effect on her behaviour, but did not find out if this were so.

Another third year student confirmed Sister Edale's observation that students in their third year resented criticism. The student, a questionnaire respondent, wrote:

Trained staff to give more 'positive' encouragement to learners as opposed to negative reactions and reports.

It was noted in chapter 6, section 6.2.1(b) that first year students appeared more willing than third year students to accept Sister Edale's 'strict' management style. However, a first warder did not experience the sister's management style positively in terms of her learning. She said:

I was there to get my objectives signed and had to go and lock myself away with Sister in the office ... real inquisition stuff ... do you know this, do you know that ... she said I wasn't applying myself to the patients or I wasn't thinking about what I was doing ... and it wasn't until I went up yesterday and got my ward report that I was told I was huffy.

A finalist thought that the sister on Edale ward, unlike many other ward sisters, used assessments in the way intended, i.e. to assess ability rather than personality. The case of the first warder quoted above illustrated the difficulty of distinguishing between the assessment of ability (lack of application and thought) and personality ('huffy' behaviour). On this occasion, feedback was not given after four weeks, but on completion of the student's allocation to Edale ward.

A questionnaire respondent summarised a number of factors which influenced the ward learning environment on Edale ward. These factors included the way in which individual students reacted to the sister's particular style of management, the importance of hierarchy in militating against and empathy in facilitating ward learning. The references to braving 'the initial fear' and allowing individuality to be preserved suggest the management of feelings as part of the emotional labour process.

The student, a third warder, wrote:

I was happy with the system of teaching and overall atmosphere in this particular ward. But I have found it very much dependent on the nurse herself to 'brave' the initial fear of a trained staff uniform, and ask questions. If that particular member of staff remembers what it was like to be a first year student, then learning is available and your 'individuality' preserved.

As in common with other wards, students tended to see a clear distinction between being taught and giving care. Supervision and feedback on performance were, as the sister perceived, resented, particularly by third year students because they were not used to being monitored in this way, but also by more junior staff. Early on in their training as the above accounts show, students, because they were not

supervised in a systematic way, might see any intrusion on their work organisation as reflecting negatively on their abilities.

8.2.2 Windermere ward

(a) The ward sister's views of teaching and learning nursing

During interview, Sister Windermere described contact with the school of nursing as 'hardly any' since the clinical teacher had left. One of the senior tutors came from the school once a week to give student tutorials, but she and the sister rarely had contact.

As stated in chapter 4, section 4.2.1 (see p.159), Sister Windermere recognised that learning could be improved if the students were made aware of the learning potential inherent in their ward activities:

Tutors say 'students don't know they are learning'. I wonder how far you can go on saying that if the students don't realise they are learning. They would learn more if they realised that they were (learning).

The sister was aware that all students needed emotional support whilst working on the wards. She thought that the needs of third year students were different and less obvious than the needs of first year students, and so could get overlooked. Of the finalists she said:

We tend to use them as senior nurses without them getting a whole lot back.

The sister held clear views on the clinical teacher's role. These views were based on positive experiences of working with a clinical teacher who had left. Sister Windermere said that because the clinical teacher had been a ward sister she occasionally helped the trained staff when the ward was busy. The sister regarded her as a peer who was able to support not only students, but all members of the ward staff. She had a plan of working with students, monitoring their progress and giving feedback both to them and to the trained staff. Sister Windermere gave an example:

S was so useful because she would say 'Nurse X says she hasn't done much of so and so but she's going to A ward so will do lots of that there'.

The clinical teacher also prepared students for their management assessments. The secret of her success in Sister Windermere's view was that she was on the ward at least half the working week, which allowed her to integrate and know what was going on.

The sister had been asked in the past to contribute to panel discussions on patient care, in the school with other health workers but this had not happened recently. She had also been invited to speak on the staff nurse professional development course.

As discussed in chapter 4, section 4.2.1 (see p.159), she felt that the school of nursing was 'under-used' and that students manipulated it against the ward. She said:

Students say one thing to the ward and another to the school ... they come from block and say 'we didn't learn anything and it was dreadful'. It happens here on the ward. When pressed, the students say 'well, we learnt practically'.

The sister was asked if she ever contacted the school of nursing. She gave two examples: if she was worried about students' poor performance in assessments, and when the ward establishment had fallen from six to three trained staff members. The sister discussed the situation with the ADNS, because she felt that there were not enough trained staff to support the students. The ADNS was sympathetic and advised the sister to record any deficiencies in patient care which occurred due to staff shortages.

It was noted in chapter 6, section 6.2.2(c), that Sister Windermere used the nursing process as a way of giving one to one reports about patient care to find out what the students were doing. She thought that there was a general assumption amongst trained staff that third year students did not need to report in this way. Consequently there was insufficient contact, in her view, between trained staff and third year students. The sister said that she now tried to give positive feedback to all students in order to encourage them to discuss their work.

(b) Students' formal and informal learning

During the study period there were no formal teaching sessions organised by Windermere's trained staff. Both the sister and staff nurses were aware of the deficiency. One of the staff nurses was concerned about the lack of 'sit-down tutorials' which had been a regular feature of her own training. She saw the organisation of these tutorials as part of the clinical teacher's role. She implied that the demands of patient care on Windermere ward took priority over formal student teaching. Another staff nurse thought that 'you do need sit-down tutorials, but as first years you learn from working with others'.

However, a newly qualified staff nurse commented to the researcher one day when the ward was well staffed: 'I should work with the first warders really, but there are only bed baths and things to do'. Such activities were not seen to require supervision despite the inexperience of first ward nurses.

During one unusually quiet weekend, the sister informed the students that she wanted them to observe other nurses communicating with patients and observe for 'faults'. An example she gave of a 'fault' was the way in which nurses inappropriately addressed patients by names such as 'poppet'. The sister later told the researcher that she did not have a feedback discussion with the students as she had intended.

It was noted in chapter 6, section 6.2.2(b), that some students disliked the sister's style of management because of its informality and emphasis on patient communication. All the students recognised that she was committed to the use of the nursing process but not that she used one to one reporting as a teaching tool. The third year students especially resented not having formal teaching sessions and they were unanimous that they wanted regular tutorials. A questionnaire respondent on her third ward gave a less usual example of learning when she wrote that one of the most valuable experiences for her education

on Windermere ward had been 'trained staff (who) encouraged team spirit which taught me to work and give feedback to other staff'.

The combination of heavy workload, low staffing levels and a flexible patient centred approach to care could sometimes militate against learning, as exemplified by a first warder's outburst observed by the researcher. The student had just returned from a long weekend off duty. She was on a late shift and was sitting in the office having her tea break with the staff nurse and the researcher. The first warder suddenly began to pour out her feelings. She said that Windermere had been a 'bad' choice of ward for her first allocation. She had dreamt several times that she was on the ward in her nightdress giving commodes to patients. The student perceived her problem in the following way. She had not studied 'A' level biology before coming into nursing and so felt 'theoretically' ill-prepared by the foundation unit for working on the ward. She also felt that she was not learning anything whilst she was on the ward, nor putting into practice what she had learnt in school. She reflected: 'Maybe I've just had too easy a life before I came into nursing'. The staff nurse was surprised by the outburst and said: 'But you always seem to know what you are doing'.

The student's anxiety (indicated by her dreams) appeared to originate from a belief that her lack of biology qualifications and the generality and volume of the work on Windermere ward rendered it a 'bad' first ward allocation. On the one hand she felt she had insufficient knowledge to understand the nature of the ward work. On the other, she perceived the work as too basic for learning or for putting into practice the 'theory' she had learnt in the foundation unit. The staff nurse was surprised by the outburst because the student appeared to know what she was doing. This account draws attention to the need for trained staff to make student learning accessible in an active way, rather than assuming that first warders either knew what

they were doing or that the work was too basic to require teaching or supervision.

Other junior students also remarked on the lack of formal feedback on their work from trained staff, as illustrated by the quotation below:

Nobody ever checked what you were doing. You'd be expected to get on and do your kardexes ... you could just ask other students ... the only teaching was from the third years.

This quotation illustrates that despite a management style that was open and supportive, third year students played an important role in teaching and supervising first year students. A first year student confirmed for example that 'You get your support from other students ... during coffee'.

(c) The role of formal training requirements in the teaching/learning process

Student assessments and the giving of ward reports were observed to be disorganised on Windermere ward. The researcher noted that the students frequently reminded the trained staff of their need to be assessed. When the researcher asked a third year student about her forthcoming management assessment, she said:

Yes, I've got to do it, but they are very disorganised up here ... I don't know when I'll do it.

Two first year students were not formally assessed until their last day on Windermere ward. The third warder said that the day of her assessment had been one of the worst shifts she had experienced on the ward. All her patients were faecally incontinent. The sister had watched her intermittently and then had asked the staff nurse to see her give one of the demented patients a bath. The staff nurse did not observe the student bathing the patient because she became involved in a consultant's round. The researcher detected a hint of hysteria in the student's voice when she said at the end of the assessment 'This is my last day on Windermere!' She passed her assessment but was disappointed

that it had not been conducted more systematically.

During the first warder's assessment, the sister who was the assessor disappeared for a short period. A finalist, who was working with the student, offered to observe the student on the sister's behalf. The sister refused the offer. The first warder was assessed as 'excellent' but, like the third warder, she too felt that the assessment had been too disorganised to merit such a positive result.

Even though the actual assessments were often disorganised, the sister and staff nurses were seen to teach third ward students on the drug rounds in preparation for their drug assessments. A third year nurse was also being prepared for her management assessment by the trained staff who told the researcher that she was the sort of student 'we get a feeling that we need to work with'.

Ward reports were rarely completed for the students to take with them at the end of their allocation to Windermere ward. They usually returned to collect them once they had left the ward.

There were no observed incidents of students on Windermere ward receiving negative feedback. This may have been an indicator of the open management style that the sister operated, and the friendly and approachable attitude of the trained staff to students. The researcher observed one example of a staff nurse recognising the vital contribution of a third year student to the successful rehabilitation of an 85 year old patient.

As described in section (a) above, the sister was aware of the need to emphasise positive feedback to students, not only through formal assessments but as a part of the work routine. No student gave any examples to the researcher, nor were any observed, in which students were given 'bad' ward reports without being prepared for them.

Students on Windermere ward sometimes had difficulty in realising that they were learning because of the type of work associated with a

dependent elderly patient population and the lack of formal teaching and supervision by trained staff. The friendliness and openness of the sister's management style sometimes militated against the creation of learning conditions on the ward, as indicated by the disorganised way in which students' assessments were conducted. The situation was aggravated by the volume of the workload and shortages of trained staff.

8.2.3 Ronda ward

(a) The ward sister's views of teaching and learning nursing

During interview, Sister Ronda assessed the contact with the school of nursing as poor. There was no liaison tutor appointed to the ward and the tutorial staff rarely visited. The sister contacted the school only if she was concerned about a student's poor performance.

The sister said she told the students at the beginning of their allocation that it was their responsibility to ask whether they could watch investigations and procedures being performed on their patients.

The sister felt that with first warders 'you moulded them', but that 'it was bad for them' when the ward was busy. She considered that they were not taught enough anatomy and physiology in the school to understand the conditions, treatments and significance of observations of patients undergoing gastroenterological interventions. She also thought that the patients suffering from leukaemia put an emotional strain on the first warders, who had not yet learnt how to talk to patients.

She thought that the learning needs of more senior students were less specific because they had grasped the 'basics' of patient care. Third warders were still lacking in knowledge but could write care plans and were becoming familiar with common patient problems.

Students at the beginning of their third year were often apprehensive and insecure and needed reassurance to recall skills and

boost their confidence. Senior third year students had to do their state final examinations and needed to plan their own study.

The sister was concerned that students seemed more interested in technicalities, like watching investigations, than in basic nursing care. She attributed this to the students being told in the school 'to go and ask to see investigations' (and reinforced by the ward learning objectives). Students appeared to be more concerned with technical care and not interested in looking after long-stay elderly patients.

The importance of third year students to the ward was acknowledged by the sister who said:

We've got some very nice students at the moment ... Third years can change the whole atmosphere of the ward.

Sister Ronda had not been asked to teach students in the school, but thought that she should have been, since ward sisters rather than tutors were the specialists. She taught on the staff nurse professional development course.

(b) Students' formal and informal teaching

Informal discussion and observation on the ward yielded additional information on the learning environment.

The sister had implemented a system of teaching cards on the conditions, treatment and nursing care for patients most commonly admitted to the ward. Staff nurses were encouraged to add to the cards. These cards were used during tutorials on gastrointestinal diseases by trained staff and students. Tutorials did not take place very often during the researcher's time on the ward. First year students were critical of the lack of tutorials while they were on the ward. They thought that there could have been more teaching, since the ward was not busy.

As shown in chapter 6, section 6.2.3(b), students regarded the sister as efficient, competent and knowledgeable. Only those students who felt able to approach the sister for information described her as

'a good teacher'. A module 14 student said: 'Sister would tell us everything if we asked'. The student's comment reflects the sister's view of teaching and learning as the student's responsibility rather than hers. A third warder told the researcher that 'Sister could teach you an awful lot; she taught me to do dressings'.

As described in chapter 6, section 6.2.3(b), first warders often felt unable to approach the sister for information. One first warder felt less in awe of the staff nurses, whom she described as 'really nice, friendly, pleasant and keen on teaching'. She also mentioned that the third year students who were revising for state examinations were also good teachers. As on other wards, third year students played an important role in supervising and supporting first year students. They were considered by some students to be more approachable than the trained staff.

A staff nurse agreed just how important third year students were; something she hadn't realised as a student herself. When asked what made the present third year students so good, trained staff replied:

They're kind and quiet in their manner. They sit and talk when they can, especially with old patients. They use their initiative. They turn patients and do things for them. They don't have to be asked.

However, trained staff were physically accessible to students because they involved themselves with patient care on the ward. They were observed to respond to requests for help. On one occasion, a junior student was bathing a patient when his rectum prolapsed. She approached the staff nurse who immediately left what she was doing and went with the student to attend to the patient.

On another occasion a third warder asked the sister to look at a rash that she had noticed whilst washing one of her allocated patients. The sister commented to the researcher on returning from examining the patient that: 'You can always tell those students who wash their patients properly'.

During interview, a third year student was discussing the strains of nursing oncology patients on Ronda ward. She said that a combination of failed treatments and their side effects left patients depressed and demoralised. When asked whether nurses discussed these problems, she thought that it was 'very much a matter of staff nurses supporting staff nurses and students supporting students'.

(c) The role of formal training requirements in the teaching/learning process

Sister Ronda described the formal assessments that the students performed throughout training as 'heavy going' for the ward sister and of no advantage to students. She thought that students did not take the assessments seriously because they were always doing them. Sister also thought that the assessment guidelines issued by the school were too 'woolly' and that there was insufficient emphasis placed on the assessment of student nurses' technical skills, such as drug administration.

A first warder described her assessment by the senior staff nurse in the following way:

She was with me all morning getting an old patient up and washing him. And then she quizzed me about patients on my side, why we were doing things - that makes you think ... because I tend just to go ahead and do it, like the four hourly observations. If someone assesses you, you find out that you do know.

A student in module 12 commented on her questionnaire that her management assessment 'was one of the least stressful assessments I've done'.

The sister and trained staff rarely gave feedback to students other than through the formal assessments and ward reports. A third warder described the uncertainty of not receiving feedback in the following way:

I keep thinking they're (ward staff) watching me. It's probably me (implying her own oversensitivity).

However, in one instance, a third year student was dissuaded from leaving nursing because of receiving constructive feedback from the sister. The student was halfway through her module 12 allocation. The

sister observed that she appeared apathetic. She asked the student to come and see her. The student told the sister that she had seriously considered giving up nursing but as she was so close to completing her training had decided to continue. The sister told her it was not fair to patients to carry on if she was so unsure about wanting to be a nurse. The sister suggested that if she taught the new students on the ward she would be rewarded by their enthusiasm. As a result of the sister's suggestion, the third year student began to teach junior students and take more interest in her work and decided not to leave. The student wrote in her questionnaire:

At the beginning of the allocation, I was going through a period of wanting to leave nursing but sister recognised this and was very supportive through a difficult period.

Students on Ronda ward recognised that the sister had knowledge related to the specialty of the ward, although they were critical that she did not formally share it with them by giving tutorials. The sister regarded teaching and learning as the student's responsibility. However, because she involved herself in patient care and encouraged the staff nurses to do so, they were accessible to the students on the ward to give information and feedback.

8.2.4 Kinder ward

(a) The ward sister's views of teaching and learning nursing

During interview, Sister Kinder deemed the contact between the ward and the school of nursing to be very poor. The sister looked back favourably to the time when she was first in post on Kinder ward. A clinical teacher had visited regularly to work at least once with students in each allocation or with 'students we were worried about'. He had also given tutorials on general medical and 'abstract subjects' whilst the ward staff had taught the 'specialist topics'. The sister thought that the school was short staffed but that the tutors were out of touch with the real situation of the ward:

They would appear willing whenever they were contacted, but some of them have been over there for years and have no idea what it's like in the wards and their ideas don't fit.

The sister said that all students who were allocated to Kinder ward were able to learn about 'hearts'. They also learnt that people recovered from heart disease. The sister aimed to educate the students, not only in the general medical care of patients with heart disease but also its prevention. Third year students gained good management experience at weekends, when the trained staff were either off-duty or in the coronary care unit. As noted in chapter 6, section 6.2.4(a), the sister was aware that students did not like being in charge, but she thought that it 'did them good'.

Juniors learnt basic care and common sense. The sister thought that Kinder was a good ward for first warders as it was not too 'hectic and traumatic'. She said: 'We're teaching them the basic ways, to use common sense and build their confidence'. Of the third year students, the sister said: 'They can question technical things'. She dispelled the belief that Kinder ward patients suffered more cardiac arrests than on other wards.

The sister said that she got an 'air' from a student as to how they were progressing. She also thought that she had a responsibility to teach the students, since their performance reflected on the ward sister. After four years in post she admitted that she now found it tiring to repeat the same information to every new group of students.

In the past, the sister used to be contacted to give specialist classroom sessions on cardiac conditions, monitors, and the interpretation of electrocardiographs. Tutors had 'phoned up to ask for current cardiac information. But even this contact was no longer maintained. Recently, a tutor had visited first warders and had offered weekly tutorials to all the students. Nothing more had happened.

(b) Students' formal and informal learning

The sister was committed to organising formal teaching sessions for students. During the research period she made a concerted effort to organise the staff nurses and house officers to give the students tutorials in the afternoon. Topics included diseases which were common on the ward, such as myocardial infarction, hypercalcaemia and anaemias. The sister also arranged study visits to the intensive therapy unit, the patient services office and the mortuary.

She thought that, because Kinder ward was quieter than many other wards, there was more opportunity for teaching. Kinder ward certainly had more formal teaching sessions than the other study wards.

None of the students reported any significant contact with tutors or clinical teachers. Two first warders thought that the staff on Kinder ward displayed a negative attitude towards the school of nursing, illustrated by such comments as 'we don't do it like this here' about a number of procedures such as cardiac resuscitation and giving bed baths.

As described in chapter 6, section 6.2.4(b), the main feature of the sister's management style that students positively identified, irrespective of stage of training, was the commitment of trained staff on Kinder ward to formally teaching students.

One module 3 student wrote on her questionnaire that she 'felt the teaching and willingness of staff nurses and sister on this ward far excelled any previous ward teaching experience'. However, another third warder said that she had not had much formal training whilst she was on the ward because there had been a shortage of students (i.e. the work force). She gave a specific example:

One of my ward objectives was to go and watch a cardiac catheterisation, but there was never enough staff.

The sister confirmed the student's observation a few weeks later when she told the researcher that the trained staff had been letting the

teaching slip because of an increase in workload.

This situation improved whilst the researcher was on the ward. The ward teaching tradition was confirmed by the questionnaire comments. Five out of eight students said they had valued some form of teaching on Kinder ward. The questionnaires spanned the full study period. According to questionnaire respondents, formal teaching included not only tutorials but also observation of cardiac catheterisation, study visits to the outpatient department and going on consultants' rounds. The students learnt informally by observing other nurses carrying out specific procedures such as sutures being removed, suppositories and injections being given. The students also asked questions, particularly of the third years. One student identified a staff nurse whom she could always ask: because 'she was a caring person ... she knew you were new and she'd help as much as she could'. Another student regretted that the drug round was not always 'done correctly' and therefore might mean that she could get 'into bad habits'.

The third year students played an important role in teaching and supervising the junior nurses. Their importance in providing positive or negative emotional support to juniors was described by a module 12 student who was on Kinder ward at the same time as the researcher. She described some of the third year students as giving the first years 'a hard time' and their 'bossiness' upsetting them. A student in module one 'found some of the third years were very good and others are much more out to impress'. Another first year student said of a finalist: 'It's nice to see a third year who still enjoys it (nursing) ... E is just so keen, and it's lovely'.

The student felt she got to know other students at coffee time and when making beds. Her colleague thought that, because nursing was a job which kept you on your feet, there was not much opportunity to get to know other nurses, except at the level of saying 'hello'.

(c) The role of formal training requirements in the teaching/learning process

The sister took student assessments and ward reports seriously. The staff nurses also conducted assessments once they had attended a course to prepare them to do so. There were no clear assessment guidelines in the sister's opinion, and she felt that it was left to the ward staff to develop them. She had never failed anybody, because she always made it clear to the students that she would not let them take the assessment if they were not going to pass. She thought that the advantage of continuous assessment was that staff were aware of a student's competence before proceeding with the formal assessment.

As noted in chapter 6, section 6.3.3(a), students' questionnaire comments suggested that trained staff created stress/anxiety for some students by the way in which they handled their ward reports. This appeared to be the case on Kinder ward. A third warder wrote about her ward report:

Staff nurses feel they should write particular comments, which can be grossly misinterpreted by the person out of the ward.

One questionnaire respondent felt that inappropriate comments had been written on her halfway report, suggesting that she was quiet and had looked miserable. The student added: 'I do tend to feel nervous at the beginning of an allocation but it was made worse by these comments'. A first warder said:

I thought they just felt you had to have a ward report and someone just filled it in ... I didn't think I'd improved much from the halfway report. I don't know if they actually know what we did ... how we talked to people. I wasn't very good at some things, but I thought 'well, I was good at that'.

Another first warder disagreed and thought that the staff nurses knew the students quite well.

Students did not receive feedback on their progress, other than through formal assessments and ward reports. One student found 'that was one of the problems, because all the time you thought you could do

it because no one was telling me what was right and wrong'. A second student confirmed this philosophy:

Sister said at the beginning: 'You'll know if you're not doing very well; we'll tell you. If we don't say anything, then it's fine.

A third year student described her management assessment as:

... very helpful. Most people dread their management assessment and it's such a dreadful day, people get so worried. But on Kinder ward I wasn't so worried about it and sister was very helpful and everything. Constructive criticism is really helpful, without being a real trauma.

A first warder said that despite being assessed by 'this staff nurse who can put you down a lot' she:

... really enjoyed doing it ... I was kept busy and I got everything done and I think that's why I passed. I don't think the staff nurse kept an eye on me, because it was really busy.

Another first warder's assessment has already been described in another context (chapter 6, section 6.2.4(c)). Her colleague, who was on duty during the assessment when a misunderstanding about filling in a fluid balance chart occurred, thought the staff 'weren't very good about it ... it would have been nice if someone had said "it's a mistake; don't worry"'. The student concerned, however, thought the staff were 'quite sympathetic. I just don't think they realised how sensitive I was; it destroyed my confidence'.

The hierarchical relationships inherent in nursing and the fear of being assessed by trained staff is apparent in the following statement made during interview with two first warders who had worked with the researcher on a number of occasions:

It was nice working with you because you didn't write our reports ... also being there all the time. You were very good about us not knowing anything, and not making us feel silly. Even making a bed with staff nurse is difficult.

The researcher was many years senior to the staff nurses but, unlike them, had no bureaucratic control over the learners.

The trained staff on Kinder ward had an explicit commitment to formal teaching which was valued by all students. The system of

practical assessment and ward reports and the hierarchical nature of nursing relationships created anxiety and stress for some students. However, the commitment of the ward staff to formal teaching and the specialist nature of the work appeared to counter these negative aspects of the ward learning environment.

8.2.5 Summary of case study material

Case study material from four wards confirmed the findings that ward sisters saw their first commitment to patient care, rather than student teaching. However, Sisters Edale and Kinder also articulated a clear commitment to the organisation of formal teaching. Sister Kinder made the link during interview between student performance and ward sister responsibility.

All the ward sisters recognised that students had different learning needs at different stages of training. The beginning of training and the beginning of the third year were identified as particularly vulnerable periods for students. However, both Sister Kinder and Sister Ronda described some of the demands experienced as a consequence of their responsibilities to the students. Sister Kinder described the continual need to teach new groups of students as 'tiring'; Sister Ronda described the continuous assessment (of up to seven students every few weeks) as 'heavy-going'. All the sisters believed that nurse teachers had primary responsibility for nurse training in the school and wards.

The ward sisters saw the need for increased contact between teachers from the school of nursing and the ward, particularly in the way clinical teachers had worked in the recent past (i.e. to organise both formal tutorials and work with students in caring for patients). Sisters Edale and Windermere believed that if tutorial staff were to make a positive contribution to the ward learning environment, they needed to develop a continuous relationship with patients and staff.

The researcher observed that the development of such a relationship might prevent teachers putting unrealistic demands on students whilst working with them on the wards.

Ward sisters were no longer asked by teachers in the school to teach students about their specialities. With the exception of Sister Ronda, who was more recently appointed than her counterparts on the other three wards, the sisters said that the contact with the school of nursing had noticeably declined in the last two years. Sister Ronda had never experienced it as good, having been in post for only eighteen months. Staff shortages in the school were offered as an explanation for the reduced contact between tutorial staff and the ward. No explanation was given as to why they were no longer asked to contribute to classroom based sessions with students.

All sisters gave examples of initiating contact with members of the tutorial staff. Their reasons for contacting the school was usually to deal with problems associated with students' poor performance on the ward, often during assessments.

Sister Windermere, like the surgical ward staff nurse described by a third year student in section 8.1.3(a), contacted the school of nursing when she felt that the ward resources were inadequate to maintain student learning and support. Furthermore, in keeping with her recognition of students' need for support, Sister Windermere was the only study ward sister to identify the need to give positive feedback and support to all students. As described in section 8.1.3(c), a third warder recognised the giving of positive feedback to all grades of students during her allocation to Windermere ward.

Sister Ronda, through her direct involvement in patient care, was accessible to students to teach, supervise and give feedback.

Sister Windermere was the only sister who articulated the need to teach communication as a specific skill rather than an ability to

acquire through accumulated experience. This finding was in keeping with her recognition of emotional labour as a visible component of nursing. Other ward sisters, whilst recognising that students needed to become more experienced at talking to patients, did not teach them how to do this. Rather, they emphasised the acquisition of technical skills and medical knowledge through their teaching as indicated by the tutorial topics.

The sisters and trained staff used the formal training requirements (continuous assessments, learning objectives and ward reports) as a focus for teaching and as a means of assessing students' knowledge and skills and giving them feedback on their performance. Some students felt that the assessments were also used as a means of criticising them personally as well as technically. They particularly felt uneasy about the assessments on Edale ward where the sister believed in giving students honest feedback, which by their third year they did not expect to be negative.

The students on Kinder ward experienced stress/anxiety from the way in which the trained staff handled ward reports. Both examples confirm the findings from chapter 4, section 4.3.3 (p.186), that methods of assessment at the City school of nursing served indirectly to supervise students to do emotional labour.

However, the sisters appeared indirectly and intuitively to monitor students' progress whilst on their ward.

Windermere and Ronda wards offer examples of the importance of making learning experiences 'intelligible' (Revans 1964) and recognisable (Fretwell 1982) to students at different stages of training.

The incident of the first warder's outburst on Windermere ward is an example of the learning experience not making sense to the student even though the care was described as 'basic', if she was not able to

directly discuss what she was doing with an experienced nurse. On the other hand, she appeared to the staff nurse to know what she was doing. On Ronda ward, students were able to identify the sister's technical competence and specialist knowledge of the medical conditions on her ward. They were unaware, however, that she believed she 'shouldn't need to tell students what to do'.

In terms of students' views of ward learning, the case studies supports the findings presented in section 8.1.1 about the formal and informal ways in which students learn on the wards and chapter 5, which described their preferences for nursing patients that generate technically and medically orientated learning material. Assisting patients with activities of daily living, the so-called 'basic' nursing care, was not always perceived as generating learning in the early days of training, even when recognised as such by the sister as on Windermere ward. Students considered that they learnt from other nurses, particularly if they appeared 'caring' and empathetic towards them. Thus they recognised when nurses did emotional labour on their behalf. Students were more likely to identify other students in this way because they appeared to be more approachable given their lower place in the hierarchy than trained staff. Ward management styles were important in creating a supportive environment as illustrated particularly by Windermere ward, which reduced but did not remove the obstacles to learning created by the hierarchical nature of the relationships among nurses.

The findings of Ogier (1982) and Ogier and Barnett (1985) are of relevance here. These researchers showed that the ideal learning environment for students was created by a sister who had a leadership style that showed 'high consideration' and 'moderate structure'. High consideration was indicated by warm relationships towards students. The findings presented in the case studies show that Sister Windermere more

than any of the other sisters demonstrated a style that was 'high' in consideration. 'High structure' was indicated by a sister whose leadership style showed purpose, direction and organisation. 'Moderate structure' was a more flexible style by which the sister created teaching and learning opportunities for the students. On these criteria, Sister Windermere demonstrated a style with a low structure which may have prevented students from recognising that they were learning on her ward. The other sisters demonstrated moderate to high structure but lower consideration. Teaching was explicit on Kinder and Edale wards. The findings are inconclusive and do not at this stage of the analysis confirm the working hypothesis that:

Sisters who are accessible and approachable are more likely to provide teaching and learning opportunities for students and meet their learning and emotional needs, rather than those who are not.

It is possible that the hypothesis needed to be refined in order to look at teaching and learning as separate but interrelated activities. The questionnaire findings which follow are used to explore the hypothesis further.

8.3 Ward Learning Environment Questionnaires; Student Ratings on Ward Teaching and Learning

In this section the questionnaire findings are presented to provide additional evidence to findings obtained during interviews and participant observation. Tables 8.1-8.5 show item and section scores or ratings obtained for 12 medical wards. For consistency, all scores shown in the tables are presented in original rank order of the overall scores (chapter 5, table 5.19). Figures 8.1-8.5, which accompany the tables, demonstrate the significance of the findings at the 0.05 level when mean scores were compared between pairs of wards using Gabriel's test.

As was established in chapters 5 and 6, medical specialty, based on the predominant diagnosis of the patient population and ward sisters' management styles, shaped students' perceptions of a favourable

learning environment. Their perceptions were also shaped by the interplay of other variables such as feelings of stress/anxiety, adequate staffing levels and mix of trained and student nurses.

During interviews and participant observation it emerged that additional variables to be considered were the motivation of the trained staff to teach and/or provide learning opportunities.

Firstly, questionnaire scores relevant for describing students' perceptions of the trained staff's motivation to teach and learn on the ward were: item 1: 'This was a good ward for student learning'; item 3: 'I learnt very much on this ward'; section C: Ward teaching; and section D: Provision of learning opportunities. Item 7: 'The workload does not interfere with teaching or learning' was used as an indicator of the interplay between workload, staffing levels and trained staff's motivation to teach and provide learning opportunities for the students.

Secondly, relationships between scores on different items and sections, including those presented in chapters 5, 6 and 7, were tested using Pearson's correlation coefficient.

Thirdly, an analysis of responses to open-ended questions 37-41 on the questionnaire are presented in section 8.3.3, as additional evidence to support findings obtained from other methods of data collection.

8.3.1 Item and section scores

The ratings or scores presented in table 8.1 ranged from 4.38 to 3.23 for the 12 medical wards under study. The wards which obtained a score significantly lower (figure 8.1) than 9 other wards were Windermere, Loughrigg and Ullswater wards. These scores confirmed their overall low ranking as learning environments (chapter 5, table 5.19) in 10th, 11th and 12th place. Their scores were not significantly different when compared with each other.

The scores awarded for item 3 (table 8.2) were indicative of the students' perceptions of their learning on a ward. The scores ranged from 4.40 to 3.22. Only Kinder ward achieved a score that was significantly higher when compared with all other ward scores (figure 8.2).

Table 8.1

Students' ratings of 12 medical wards on item 1:
'This was a good ward for student/pupil learning'

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	4.38	.73
2. Eskdale	35	3.97	.74
3. Wastwater	34	3.97	.57
4. Ronda	43	3.95	.57
5. Edale	51	4.12	.86
6. Buttermere	35	3.86	.96
7. Ambleside	47	3.79	.92
8. Langdale	29	3.79	.85
9. Coniston	38	3.74	1.09
10. Windermere	52	3.35	1.17
11. Loughrigg	62	3.23	1.29
12. Ullswater	50	3.24	1.09

Figure 8.1

Gabriel's test of significance at the 0.05 level for comparison
between scores obtained on item 1

WARD NUMBER	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	N	N	N	N							
6	N	N	N	N	N						
7	S	N	N	N	N	N					
8	N	N	N	N	N	N	N				
9	S	N	N	N	N	N	N	N			
10	S	S	S	S	S	S	S	S	S		
11	S	S	S	S	S	S	S	S	S	N	
12	S	S	S	S	S	S	S	S	S	N	N

S = significant at the .05 level. N = not significant.

Table 8.2

Students' ratings of 12 medical wards on item 3:
'I learnt very much on this ward'

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	4.40	.82
2. Eskdale	35	3.82	.91
3. Wastwater	34	3.76	.84
4. Ronda	43	3.88	.91
5. Edale	51	3.92	.89
6. Buttermere	35	3.54	1.00
7. Ambleside	47	4.00	.92
8. Langdale	29	3.59	.95
9. Coniston	38	3.80	1.06
10. Windermere	52	3.46	1.08
11. Loughrigg	62	3.39	1.25
12. Ullswater	50	3.22	1.15

Figure 8.2

Gabriel's test of significance at the 0.05 level for comparison
between scores obtained on item 3

	1	2	3	4	5	6	7	8	9	10	11
2	S										
3	S	N									
4	S	N	N								
5	S	N	N	N							
6	S	N	N	N	N						
7	S	N	N	N	N	N					
8	S	N	N	N	N	N	N				
9	S	N	N	N	N	N	N	N			
10	S	N	N	N	N	N	N	N	N		
11	S	N	N	N	N	N	S	N	N	N	
12	S	N	N	S	S	N	S	N	N	N	N

Table 8.3

Students' ratings of 12 medical wards on item 7:
'The workload does not interfere with teaching or learning'

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	3.66	1.11
2. Eskdale	35	3.89	.85
3. Wastwater	34	3.74	1.09
4. Ronda	43	3.26	1.04
5. Edale	51	2.65	1.33
6. Buttermere	35	3.00	1.07
7. Ambleside	47	3.57	1.23
8. Langdale	29	2.48	1.10
9. Coniston	38	2.32	1.07
10. Windermere	52	1.38	.52
11. Loughrigg	62	3.44	1.24
12. Ullswater	50	3.30	1.14

Figure 8.3

Gabriel's test of significance at the 0.05 level for comparison
between scores obtained on item 7

	1	2	3	4	5	6	7	8	9	10	11
2	N										
3	N	N									
4	N	N	N								
5	S	S	S	S							
6	S	S	S	N	S						
7	N	N	N	N	S	N					
8	S	S	S	S	N	S	S				
9	S	S	S	S	N	S	S	N			
10	S	S	S	S	S	S	S	S	S		
11	N	N	N	N	S	N	N	S	S	S	
12	N	N	N	N	S	N	N	S	S	S	N

Table 8.3 presents the mean scores obtained for item 7 ('The workload does not interfere with teaching or learning') which show a range from 3.89 to 1.38. Low scores were received by Langdale, Coniston and Windermere wards. All three wards were described in chapter 5 as 'heavy' medical wards with a predominance of female, elderly patients. Edale ward also received a low score which reflects the acute nature of the work on that ward, described in chapter 5. The scores received on these four wards were significantly lower when compared with scores obtained by other wards (figure 8.3). The low score (1.38) received by Windermere ward was significantly lower when compared with scores awarded to all other wards and confirms findings from participant observation and student interviews.

The scores relevant to describing students' perceptions of teaching and learning on a ward were derived from section scores C and D respectively. The items which students were asked to rate by allotting a score from 5 (most favourable) to 1 (least favourable) were on section C: Sister devotes a lot of her time to teaching learners; Trained staff teach on the ward regularly; Clinical teachers teach regularly on the ward; Consultants are interested in teaching; There are regular sessions, in which trained nurses discuss the nursing care of patients; The ward report is used as an occasion for teaching learners; Sister initiates teaching; Learning objectives are in use on this ward; Sister accords teaching and learning activities a place in the routine. Items on section D were: Trained and learner nurses work together giving a full range of care e.g. bathing and dressing; Sister and trained staff give learners an opportunity to watch or perform new procedures; Sister attaches great importance to the learning needs of student and pupil nurses; Sister gives learners the opportunity to read case notes and text books; Learners are given an opportunity to use their initiative and discretion; Learners are taught on doctors' rounds.

Table 8.4

Students' ratings of 12 medical wards on
Section C: ward teaching

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	3.49	.52
2. Eskdale	35	3.12	.62
3. Wastwater	34	3.34	.61
4. Ronda	43	2.84	.51
5. Edale	51	3.36	.57
6. Buttermere	35	3.04	.62
7. Ambleside	47	2.93	.75
8. Langdale	29	2.82	.60
9. Coniston	38	2.61	.54
10. Windermere	52	2.70	.62
11. Loughrigg	62	2.54	.61
12. Ullswater	50	2.36	.60

Figure 8.4

Gabriel's test of significance at the 0.05 level for comparison
between scores obtained on section C

	1	2	3	4	5	6	7	8	9	10	11
2	S										
3	N	S									
4	S	N	S								
5	N	S	N	S							
6	S	N	S	N	S						
7	S	N	S	N	S	N					
8	S	N	S	N	S	N	N				
9	S	S	S	N	S	S	S	N			
10	S	S	S	N	S	S	N	N	N		
11	S	S	S	S	S	S	S	N	N	N	
12	S	S	S	S	S	S	S	S	S	S	S

Table 8.5

Students' ratings of 12 medical wards on
Section D: provision of learning opportunities

WARD	NUMBER	MEAN	S.D.
1. Kinder	48	3.09	.44
2. Eskdale	35	2.78	.51
3. Wastwater	34	2.80	.56
4. Ronda	43	2.89	.42
5. Edale	51	2.95	.50
6. Buttermere	35	2.71	.64
7. Ambleside	47	2.80	.60
8. Langdale	29	2.79	.51
9. Coniston	38	2.77	.42
10. Windermere	52	2.80	.56
11. Loughrigg	62	2.43	.49
12. Ullswater	50	2.32	.50

Figure 8.5

Gabriel's test of significance at the 0.05 level for comparison
between scores obtained on section D

	1	2	3	4	5	6	7	8	9	10	11
2	S										
3	S	N									
4	S	N	N								
5	S	N	N	N							
6	S	N	N	N	N						
7	S	N	N	N	N	N					
8	S	N	N	N	N	N	N				
9	S	N	N	N	N	N	N	N			
10	S	N	N	N	N	N	N	N	N		
11	S	S	S	S	S	S	S	S	S	S	
12	S	S	S	S	S	S	S	S	S	S	N

Tables 8.4 and 8.5 present the mean scores obtained for sections C and D from students' ratings of 12 medical wards. The ratings or scores presented in table 8.4 ranged from 3.49 to 2.36. Kinder (3.49), Edale (3.36) and Wastwater (3.34) obtained the top three section C scores. These top scores were significantly higher than the scores obtained for 9 other wards but not significantly different when compared with each other (figure 8.4). The top ratings for Kinder and Edale wards confirm the case study findings that both sisters were motivated to teach students allocated to their wards.

The ratings or scores presented in table 8.5 showed a range of

scores from 3.09 to 2.32. Kinder ward received the top score, which was significantly higher than scores obtained by any other ward (figure 8.5).

At the lower end of the range, Loughrigg and Ullswater wards were ranked in 11th and 12th place for both scores. Ullswater received a section C score that was significantly lower than scores received by any other ward (figure 8.4). Both Loughrigg and Ullswater received low section D scores that were significantly lower than the scores obtained by 10 other wards (figure 8.5).

Overall, the scores presented in tables 8.4 and 8.5 are low when compared with section scores B (table 6.2) and E (table 7.8). The lower range of scores suggests that students' perceptions of teaching and learning were generally less favourable than their perceptions of ward atmosphere/staff relations (score B) and patient care (score E) on the wards at City hospital.

The high section C (ward teaching) score obtained by Edale ward suggests that the sister's explicit commitment to teaching, despite the demanding workload, was recognised by students.

The low scores obtained on item 7 by Langdale, Coniston and Windermere wards confirms Fretwell's (1982) findings that heavy workload and low staffing levels could interfere with ward teaching or learning. However, the significantly lower scores obtained on item 1 (table 8.1, figure 8.1) and section D (learning opportunities) (table 8.5, figure 8.5) by Loughrigg and Ullswater suggest that despite perception of lower workloads and better staffing levels on these wards (table 8.3, figure 8.3), students perceived more learning opportunities were provided (section score D) on Langdale, Coniston and Windermere. As mentioned, Ullswater also received a significantly lower section C score than any other ward. These findings suggest that workload and staffing levels by themselves did not interfere with ward teaching or

learning. The motivation of the staff to teach and provide learning opportunities also appeared to be an important factor.

8.3.2 Relationships between scores

Pearson's correlation coefficient was used to test a number of relationships between the mean scores obtained on items and sections of the questionnaire for the 12 medical wards. The decision to test the relationships between certain scores was based on findings which emerged from an analysis of data obtained during participant observation and interviews and the formulation of working hypotheses.

The relationship between workload, staffing levels and mix and ward teaching and learning were tested using Pearson's correlation coefficient between mean item scores 4, 6, 7 and mean section scores C and D. No significant relationships were obtained at the 0.05 level between any pair of variables (i.e. 6 pairs in all) confirming that the creation of the conditions for ward teaching and learning was not solely dependent on workload, staffing levels and mix.

The relationship between students' perceptions of sisters' management styles and ward teaching and learning were tested using Pearson's correlation coefficient between section score B (ward atmosphere/staff relations) and section scores C (ward teaching) and D (provision of learning opportunities). There was no significant relationship between scores B and C. However, a significant relationship of 0.64 ($p < .05$) was demonstrated between scores B and D. These scores supported the hypothesis that the provision of learning opportunities (rather than formal teaching) were more likely to be provided on wards where the trained staff were approachable and accessible to students.

On the basis of a previous finding that score B and item 2 ('I am happy with the experience I had on this ward') were strongly positively correlated (chapter 6, section 6.3.2), the relationship between item 2

and section scores C and D were also tested. Both relationships were positively correlated but the correlation between item score 2 and section score C was less strong (0.56, $p < 0.05$) than the correlation between item score 2 and section score D (0.79, $p < 0.01$).

These findings further support the hypothesis that students' perceptions of favourable management styles and feelings of wellbeing on a ward were more important to their perceptions of the provision of learning opportunities than being formally taught.

However, the predominant belief among trained and student nurses was that learning was dependent on formal teaching, as confirmed by a strongly positive correlation between scores C and D (0.79, $p < 0.01$).

These findings show that students held two views of ward learning: one that formal teaching was important to learning, the other that interpersonal relationships made a major contribution to favourable ward learning environments through the provision of learning opportunities associated with ward management styles and consequent student wellbeing.

Relationships between the nature of the work and student perceptions of the ward as a learning environment were tested using item score 5 'There is very much to learn on this ward' (as indicative of the learning potential on a ward) and item score 3, section scores C and D (3 pairs of variables). No significant relationships were demonstrated which confirmed the finding in chapter 5 that ward speciality alone was insufficient to create a favourable learning environment as perceived by students. The lack of a significant relationship between students' perception of potential and actual learning on a ward suggests that students' expectations for ward teaching and learning were unfulfilled, a finding which was confirmed by low section scores C and D (tables 8.4 and 8.5).

Finally, relationships between the section scores E (table 7.8) and

C and D were tested in order to address the original research problem which sought to explore the nature of the relationship between quality of nursing and the ward learning environment. A significant relationship between scores C and E was obtained (0.68, $p < 0.05$) and also between scores D and E (0.74, $p < 0.01$). These findings suggest that teaching and learning and quality of nursing on a ward were related.

8.3.3 The ward learning environment on four wards: summary of questionnaire findings for four study wards

Table 8.6

Section Score B: ward atmosphere/staff relations on four wards

WARD	SCORE	RANK ORDER OUT OF 12 MEDICAL WARDS
Windermere	4.33	1
Ronda	3.99	4
Kinder	3.93	5
Edale	3.59	9

The section B score obtained by Windermere ward was significantly higher than scores obtained by 3 other study wards. The scores obtained by Ronda, Kinder and Edale were not significantly different from each other (chapter 6, figure 6.1).

Table 8.7

Section Score C: ward teaching on four wards

WARD	SCORE	RANK ORDER OUT OF 12 MEDICAL WARDS
Kinder	3.48	1
Edale	3.36	2
Ronda	2.84	7
Windermere	2.70	9

The scores obtained by Kinder and Edale wards were not significantly different when compared with each other. The scores obtained by Ronda and Windermere ward were not significantly different when compared with each other. However, Kinder and Edale ward scores were significantly higher when compared with the two other wards (figure 8.4).

Table 8.8

Section Score D: provision of learning opportunities

WARD	SCORE	RANK ORDER OUT OF 12 MEDICAL WARDS
Kinder	3.48	1
Edale	2.95	2
Ronda	2.89	3
Windermere	2.80	4

The score obtained by Kinder was significantly higher than the scores obtained by the other wards. The scores obtained by Edale, Ronda and Windermere wards were not significantly different from each other (figure 8.5).

Table 8.9

Item score 36: stress/anxiety ratings

WARD	SCORE	RANK ORDER OUT OF 12 MEDICAL WARDS
Edale	2.23	1
Windermere	2.10	4
Ronda	1.56	8
Kinder	1.44	12

The stress ratings obtained by Edale and Windermere wards were not significantly different from each other. The ratings obtained on Ronda and Kinder wards were not significantly different from each other. The stress ratings obtained by Edale and Windermere were significantly higher than the scores obtained by the two other wards (chapter 5, figure 5.9).

Table 8.10

Item score 2 on four wards: I am happy with the experience I have had on this ward

WARD	SCORE	RANK ORDER OUT OF 12 MEDICAL WARDS
Kinder	4.32	1
Ronda	4.12	3
Windermere	3.98	8
Edale	3.82	9

None of these scores were significantly different from each other (chapter 6, figure 6.2).

Discussion

The learning environment on each study ward was created in different ways. On Kinder, the learning environment was created by a ward sister who prioritised formal ward teaching. The ward specialty (cardiology) was one that generated technical nursing work which was readily identified by students as learning material. The workload was described as 'light' and the staffing levels as adequate. Stress ratings were low on the ward. The ward case study indicated that students experienced stress/anxiety, associated with the way in which trained staff handled feedback and expected third year students to manage the ward. It is possible that these feelings were reduced because of the ward sister's explicit commitment to ward teaching which fulfilled students' expectations for learning. Sister Kinder corresponded to Fretwell's (1982) ward sister who was student orientated and made ward teaching a reality.

Sister Ronda expected students to take responsibility for their own learning and patient care. Students were given work orders during handover reports but were not expected to exchange information and ideas about patient care. Formal teaching was not a priority. The nature of the work was readily identified as learning material by students because of the 'variety' of patients admitted to Ronda ward and the technical care required by gastroenterological patients. Trained staff involved themselves in patient care which made them physically accessible to students when they needed advice. Stress ratings on Ronda ward were low. The presence of trained staff on the ward may have helped to alleviate students' feelings of stress/anxiety. Case study findings suggested that third year students found the sister more approachable than first year students.

The ward learning environment was created on Edale ward by a sister who prioritised formal teaching and supervising students in giving care

to patients. Students recognised the sister's commitment to teaching but found her management style created stress. Their feelings of stress were reflected in Edale's top stress rating. Students also experienced stress from the acute nature of the work on Edale ward but they also readily identified the care of patients in emergency situations as learning material. The high stress ratings on Edale ward are an interesting finding when compared with the low stress ratings on Kinder ward where students expected to experience stress associated with patients having cardiac arrests. The low stress ratings appear to support Sister Kinder's view that contrary to expectations for a cardiology ward, the number of cardiac arrests experienced by patients on her ward was no higher than on other medical wards. The difference in stress ratings between the two wards where the sisters were both committed to teaching appears to lie partly in their difference in management style in relation to the supervision of students whilst caring for patients. It was shown in the case study that students (particularly in their third year) on Edale ward resented being supervised by trained staff and wanted more responsibility for managing the ward. Third year students on Kinder ward felt that they were sometimes given too much responsibility for managing the ward, but this feeling did not appear to militate against students' overall perceptions of a favourable learning environment on Kinder ward.

Windermere ward was rated less highly as a learning environment than the other study wards. The reasons for the students' less favourable perceptions appeared to lie in the elderly, dependent patient population who were not readily identified as learning material. The sister's commitment to the nursing process and communication skills was recognised by students but not automatically identified as learning material. The heavy workload coupled with the low staffing levels and lack of trained staff militated against the provision of formal

teaching and supervision. However, the sister was well recognised by students for her approachable and accessible management style and her concern for their emotional needs. The high stress ratings, therefore, appeared to originate from the heavy physical workload, inadequate staffing levels and the lack of trained staff on Windermere ward. Case study findings suggest that some students experienced stress because the sister's management style was too 'unstructured'.

In spite of the perceived differences in management style and nature of the learning material on the four wards, the score obtained on section D of the questionnaire (Provision of learning opportunities) was only significantly higher on Kinder ward. These findings suggest that the critical variables which interacted in shaping the students' perception of the ward learning environment were: the provision of formal teaching, ward specialty which was medically and technically orientated and a management style that showed 'moderate structure' as defined by Ogier (1982).

The ward case study ratings for item 2 ('I am happy with the experience I have had on this ward') were not significantly different from each other. These findings suggest that the perceived differences in the learning environment on the four wards were not sufficient to demonstrate significant differences in students' feelings of wellbeing indicated by item score 2. Overall, it is likely that different factors contributed to their perceptions of happiness on each ward.

8.3.4 Analysis of responses to open-ended questions

(a) Question 37: Causes of stress or anxiety

Causes of stress or anxiety experienced by students whilst working on the wards were discussed in relation to the nature of the work (chapter 5) and the sisters' ward management styles (chapter 6). In this section of the thesis, the causes of stress or anxiety associated with feelings about self, work and colleagues are discussed in the

context of the ward learning process. The comments are used as additional evidence to support findings on the interaction of students' individual needs and the ward learning environment, presented in section 8.1.2 and the ward case studies (8.2) above.

As presented in chapter 5, section 5.4.5(c), a total of 106 comments were yielded from 79 questionnaires and 57 replies about the main causes of stress or anxiety whilst working on a ward. It was noted that 28 out of the 106 comments were classified according to 'feelings' described as a secondary cause of stress. 9 of the 28 comments suggested that the feelings were triggered by ward management styles as an underlying cause of stress and were outlined in chapter 6, section 6.3.3(a). The reasons to create a separate category on affective comments or 'feelings' expressed about self, work or colleagues was in order to qualify the nature of stress or anxiety experienced on different wards throughout training; also to examine the implications for learning.

The 9 causes of stress categorised as 'other' are included in the discussion where relevant to an understanding of the students' feelings.

Students used a variety of adjectives to describe the feelings associated with stress and anxiety. These adjectives included the following: inadequate, unsure, boredom, defensive (1 comment each); frustration, frustrating patients, annoyance and frustration, frustration and guilt (all third year students). All but one of the reasons for feeling frustration on Windermere and Coniston wards were associated with patient care and not having the time or staffing to get through the work. A first ward student made a related comment about the workload at the end of her allocation to Coniston ward. She attributed her stress to feeling 'overworked and very tired'. The reason for annoyance and frustration on Ullswater ward was on account

of staff relations which one student experienced as 'hierarchical' and 'unfriendly'.

A student who found patients 'frustrating' was working on an oncology ward. She explained that she did not really want to be allocated to this ward because her mother had died of cancer. The student found the female oncology patients 'frustrating and often unwilling to help themselves' (module 12). The comment demonstrates that little attention was paid to this student's individual needs since it appeared that neither the trained nor tutorial staff were aware of her particular situation and/or feelings related to her mother's death.

Students in all other modules described working on oncology wards as 'sad', 'emotional' but that the 'anxiety' produced from such work was alleviated by supportive staff (4 comments). However, the module 12 student whose mother had died on an oncology ward found the ward sister 'unsympathetic'. Given the student's personal circumstances and reluctance to 'work on the ward in the first place' it is possible that the stress generated from this particular allocation seriously interfered with positive learning.

Two students whose comments were categorised as 'other' said they were stressed or anxious during their allocation because of 'personal' reasons outside their work. One student stated that she had been helped by supportive trained staff. The other student who was experiencing socioeconomic problems and insomnia did not comment further.

Thus, as described in section 8.1.2, these findings confirm that a student's individual life biography may generate stress, irrespective of the stress or anxiety particular to a ward. As established in chapter 6, the management style in operation in a ward, however, helped to alleviate both personal and ward specific stress or anxiety.

The interaction between students, stage of training and the ward learning environment was apparent in some of their comments on the

causes of stress or anxiety. For example, two first warders described anxiety as 'neutral' and stress as 'normal' for 'new' nurses. Two twelfth module students described the anxiety associated with taking their management assessments. Another student from this module and a module 14 student both found having to return to the ward in the afternoon 'when there was nothing to do' as a cause of stress or anxiety. The students would rather have been studying, working on projects or revising for finals.

As discussed in chapter 4, section 4.2.3, a tutor expressed the view held by clinical teachers that students on their first ward were unsure of their role. The students' comments on their feelings about themselves and their work associated with causes of stress or anxiety supported this view:

'I felt slow and that I should know more'; 'anxiety about how much was expected of you'; 'I was made to feel inadequate if uncertain about care'; 'anxiety about organising work'; 'working alone after working with senior nurses'.

Two other comments on causes of stress or anxiety related to a first year student not being told about a patient's death by ward staff and a third year student's difficult relations with a patient's relatives.

Thus, students experienced a range of feelings associated with stress or anxiety and a variety of circumstances that produced them.

(b) Question 38: Work most valuable to education

Students' responses to Question 38 yielded a total of 158 comments from 79 questionnaires. 100 of the comments related to the nature of the work and the learning material and were presented and discussed in chapter 5, section 5.4.5(a). The remaining 58 comments, pertaining to categories of general application to ward learning, irrespective of the type of work and patient specialty, are presented and discussed below. The categories and numbers of comments for each included: management experience (19 comments), formal teaching (10 comments), teaching

others (10 comments), teaching and working together (8 comments), staff relations (7 comments) and feelings about work which the student identified as valuable to learning (4 comments). Table 8.11 demonstrates the influence of stage of training on students' identification of work experiences of educational value other than those associated with ward specialty.

Table 8.11

Work most valuable to education according to stage of training
irrespective of specialty on 12 medical wards

	NUMBER OF COMMENTS (According to stage of training)				
	M*1	M3	M12	M14	TOTAL
N (potential) respondents	20	19	21	19	79
N (actual) respondents	9	9	19	15	52
CATEGORY OF COMMENT:					
Management experience	0	1	7	11	19
Formal teaching, e.g. tutorials	5	1	2	2	10
Teaching others	0	0	5	5	10
Teaching and working with other nurses (trained/students)	1	2	3	2	8
Staff relations	1	2	4	0	7
Feelings about work	2	1	1	0	4

Total comments	9	7	22	20	58

* M = module

Table 8.11 shows that formal ward teaching appeared to be more important to first warders than at any other stage of training. The identification of management and teaching as valuable educational experiences to third year students illustrates the influence of stage of training on their perceptions. It is possible that third year students identified working with other nurses as valuable to their learning because

they were more likely to teach and/or manage if they worked with nurses more junior than themselves.

2 comments on staff relations referred to learning 'how not to run a ward'. 4 out of the 5 remaining comments on the positive learning experiences associated with staff relations referred to Windermere ward and support case study findings.

The comments on feelings, described as valuable to education, referred to patient contact during which students learnt patience and how to adapt to patients' needs.

(c) Question 39: Work least valuable to education

As described in chapter 5, section 5.4.5(b), 66 comments were made on question 39 by 52 out of a potential of 79 respondents. 6 comments were positive in which respondents stated that all work experiences on the ward had educational value. 22 comments were made about the nature of the work as least valuable to learning. 8 additional comments suggested that feelings of stress generated from the nature of the work also militated against learning. The 30 remaining comments describing other work experiences of least educational value on a ward as perceived by students, irrespective of the type of work or patient specialty, are presented below.

The categories and numbers of comments for each included: (lack of) management experience (0 comments), (lack of) formal teaching (5 comments), (lack of) teaching others (1 comment), (lack of) teaching and working together (3 comments), (poor) staff relations (7 comments) and feelings about work which the student identified as least valuable to learning (0 comments), non-nursing duties (14 comments). Table 8.12 demonstrates the influence of stage of training on students' identification of experiences of least educational value other than those associated with ward specialty.

Table 8.12

Work least valuable to education according to stage of training
irrespective of specialty on 12 medical wards

	NUMBER OF COMMENTS (According to stage of training)				TOTAL
	M*1	M3	M12	M14	
N (potential) respondents	20	19	21	19	79
N (actual) respondents	9	9	19	15	52
CATEGORY OF COMMENT:					
Management experience (lack of)	0	0	0	0	0
Formal teaching, e.g. tutorials (lack of)	1	0	4	0	5
Teaching others (lack of)	0	0	0	1	1
Teaching and working with other nurses (trained/ students) (lack of)	0	1	2	0	3
Staff relations	1	1	2	3	7
Non-nursing duties	0	7	6	1	14
Feelings about work	0	0	0	0	0

Total comments	2	9	14	5	30

* M - module

Attention is drawn to table 8.12 and the high frequency of comments made by module 12 students. This may be an artefact, given the limitations of the sample (see chapter 3, section 3.4.2(a)), although, as shown in sections 8.1 and 8.2, module 12 was identified during interview by students, ward sisters and tutors as a critical time in training. After a second year of specialties, students returned to the general wards as relatively senior members of the ward staff. Many of them felt insecure and lacking in confidence in their new role as third year students. It is possible that because of their relative insecurity, students in module 12 identified lack of formal teaching and contact with trained staff on wards as least valuable to their

education because they would have valued both. Most of the comments which referred to lack of formal teaching on the wards suggested that the students thought that the trained staff lacked commitment rather than the time to teach.

The comments which referred to staff relations had two components. Either they related to perceived poor communication between nurses and medical staff or the students experienced the trained staff as unsupportive to them as students. One student stated that the least valuable experience for her education on Loughrigg ward was 'working with staff who want your personality to conform'.

Work which was considered of least value to education and was commented on most frequently by the students was tasks that were associated with non-nursing duties. In other words these were the sort of tasks which might have been undertaken by ward clerks if they had been employed at City hospital. Tasks categorised as non-nursing duties included cleaning and tidying up the sluice, kitchen and ward cupboards during night duty and at the weekend, running errands, escorting patients to the X-Ray department when the ward was busy and distributing and collecting patients' menus.

The first warders made the least numbers of comments to question 39, suggesting that most experiences were identified as educationally valuable at the beginning of training and confirming findings presented in chapter 5, section 5.2.3(c). The module 14 students who were at the end of their training also made few comments, probably because they felt motivated to revise and learn from their ward experience, as their state final examinations were imminent.

(d) Question 40: Suggestions for improving ward teaching and learning

68 out of a potential of 79 respondents made comments on the need to improve ward teaching and learning. Students suggested the need for more tutorials, using the ward report for teaching purposes, encourag-

ing doctors to teach students and accompany them on their rounds, more clinical teaching from trained ward and tutorial staff, especially for first year students, and improvement of the teaching sessions already in progress, to avoid repetition and to pitch them at the appropriate level for stage of training.

Students also commented on staffing levels on the wards in two ways. Either they thought that the staff overlap in the afternoons could be used more effectively for teaching purposes on some wards or that poor staffing on other wards prevented formal teaching being organised. These comments confirm questionnaire findings presented in section 8.3.1 above which suggested that the motivation of trained staff to teach as well as the provision of adequate staffing levels for the workload was necessary for the creation of the ward learning environment.

(e) Question 41: Other comments about the ward

In response to question 41, 26 comments were made on ward learning out of a total of 70 comments from 48 students. 31 students therefore did not reply to the question although some of them gave more than one comment.

Students used a variety of adjectives to describe their overall ward experience and included the following: enjoyable (9 comments); good (2 comments); helpful, useful, interesting (1 comment each).

One student described her allocation as a 'not very productive one' partly it appeared because 'the staff were not keen to teach.'

Two responses to question 41 are given in full because they illustrate the interaction between a number of variables in the creation of the ward learning environment:

Staff nurses carry out nursing care and working with students more than on any of the other wards I've been on. Sister, whilst useless from a teaching point of view, makes the ward a very friendly place and the level of stress that you were working under was very low. Trained staff were very approachable and very open to suggestions

both about patient care and teaching. When it was pointed out that there was little teaching, an effort was made to improve the situation. (Coniston ward, module 3 student).

This comment confirms the importance students attached to the provision of formal teaching in the creation of the ward learning environment even when the atmosphere created by the sister was seen as friendly, her management style approachable and the level of stress low:

Patient care was of a very high standard. 'Nurse care' was good on an emotional level (and supportive). But useless as far as teaching of conditions of female oncology ward. (Eskdale ward, module 12 student).

The second comment, first referred to in chapter 6, section 6.3.3(b), shows that even when a student perceived patient care to be of a high standard and that students' emotional needs were being met by the trained staff, she still identified the need for formal teaching. As concluded in section 8.3.1, this statement supports findings which show that students held two views of ward learning: one that formal teaching was important to learning, the other that interpersonal relationships made a major contribution to favourable ward learning environments.

8.4 Summary of Findings

The findings obtained using a multimethod approach to data collection are summarised below. The findings examined the relationship of ward management styles to the ward learning process in terms of accessibility and approachability of nursing staff to each other and the nature of the teaching and learning opportunities provided on a ward. The maintenance of adequate staffing levels and mix, the students' stage of training and the teaching input provided by the school of nursing were also considered.

The findings suggested that the extent to which students learnt on a ward depended on a number of ward factors but also on their unique learning trajectory related to stage of training, personal and learning needs.

Although there were differences between individual students' perceptions, the overall consensus was that management styles were an important factor in how they perceived the ward learning environment, especially in terms of meeting their emotional needs and alleviating stress.

Perceptions of 'good' ward learning environments reflected the predominant paradigm that learning was ensured by formal teaching. Formal tutorials were valued when geared to level of student and organised to take account of students' off-duty rotas and patient care responsibilities. When ward sisters (and some tutors) organised ward tutorials, their content emphasised the medical approach to patient care, choosing topics which reflected the ward speciality about medical conditions and treatments.

Despite the predominance of the formal teaching paradigm, students described most of their learning as informal which took place as they worked with patients and other nurses. Words most commonly used to describe the informal learning process were 'sinking in'; 'picking it up'. Students also learnt through taking nursing histories, writing records and care plans; being present and contributing to ward handover reports; contact with patients suffering from a variety of conditions; observing how other nurses cared for patients, especially in relation to communication skills, indicative of students' recognition of emotional labour as a component of nursing. Students also said that they learnt through asking questions.

Students gave examples of negative learning or 'how not to do things', especially in relation to poor communication with patients and how not to manage a ward. The examples that students gave suggested that they recognised when emotional labour was withdrawn.

Since the major part of learning appeared to be informal, ward management styles that made trained staff accessible and approachable

to students were important for the provision of learning opportunities and making learning experiences 'intelligible'. The provision of formal teaching appeared to be less dependent on accessible and approachable management styles but more on the amount of 'structure' the sister imposed on her activities with other nurses. Students also learnt by observing other nurses in a more formal way when undertaking technical procedures, watching patients undergoing medical investigations and occasionally accompanying doctors on their ward rounds and visiting other hospital departments.

Feedback to students was rarely given by trained staff, except within the framework of assessments and ward reports. The assessments and reports put pressure on students to do emotional labour by suppressing negative feelings about ward environments and patient care. Students described assessments as both positive and negative learning experiences. There was no stated consensus about the learning experience associated with ward assessments. Some students described assessments as positive and others as negative.

Patients requiring 'basic' care were soon regarded as not having teaching or learning value by junior students, a view that was reinforced by senior students and trained staff who did not see the need to supervise these activities.

Student learning was shaped by the hierarchical structure within nursing which determined not only who students worked with, but also who they learnt from. When students worked with other nurses, they preferred to work with students rather than trained staff. Students believed that they were best able to learn from other nurses, usually students, who did not threaten them hierarchically and also did emotional labour on their behalf. Third year students as a group were most frequently identified in this way.

Students quickly began to work by themselves in caring for patients

and saw this as necessary in order to become more confident. Whilst resenting lack of support from other nurses, particularly trained staff, students even when very junior still felt the need to be seen to cope alone in caring for patients.

Whilst first year students valued the teaching role of the third years, some of them recognised the limitations of the role, given that they were also unqualified.

In general, first year students were given more emotional support than third years. Some of the third year students also wanted more emotional support, especially at the beginning of their final year when they felt anxious and uncertain in their new role.

Third year students were very conscious of their ward management and teaching responsibilities. Ward staff, whilst recognising the contribution made to the running of the ward by third year students, did not always acknowledge the students' contribution.

Nurse teachers were seen as having primary responsibility for student training. They were welcomed on the ward by sisters if they worked realistically within the ward setting. Junior students expected to work with tutorial staff. If they were disappointed either by the way in which their teachers worked or because they did not visit them on the wards, they soon learnt to view their presence negatively.

By the time students reached their third year, they resented working with both tutorial and trained staff, expecting to teach and not be taught at the bedside.

Tutorial staff agreed in principle with teaching on the wards but in practice did not prioritise enough time to build up continuity and a realistic picture of teaching through caring. They usually only spent time on the wards organising and giving tutorials.

Ward staffing levels and mix influenced teaching and learning on the ward. Higher ratios of trained staff to students was no guarantee that

more teaching and learning would take place. The lower the staffing levels and ratios, formal ward teaching and the provision of learning opportunities were less likely to take place.

CHAPTER 9

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

The status of the student nurse as principal care giver led a number of researchers to assume that there was a relationship between the learning environment and quality of nursing on a ward (Revans 1964, Orton 1981). An extensive literature exists on defining the nature and quality of nursing and the ward as a learning environment. Researchers agree on the characteristics which provide a good ward learning environment (Orton 1981, Fretwell 1982, Lewin and Leach 1982, Ogier 1982) but attempts to define quality of nursing have proved more controversial. The physical, technical and affective components of nursing have been identified but Evers (1982), for example, suggests that the 'essence' of quality is a relative concept and defies quantification. The importance of the nurse's caring role in relation to its physical and affective components, and its formalisation through the nursing process, are emphasised by nursing leaders such as McFarlane (1976, 1977). However, the gap between the professional rhetoric of caring and nurses' own work priorities and preferences suggested the need in the present study to reassess the concept of quality of nursing and the learning environment, in the light of Hochschild's (1983) analysis of the emotional labour process.

A multimethod research approach was used to explore the relationship between quality of nursing and the ward as a learning environment for students in training. Data were gathered, handled and analysed as the study progressed, in order to develop and explore working hypotheses related to the research problem.

The findings described patients' and nurses' perceptions of quality of nursing in relation to its physical, technical and affective components. Even though students preferred technical nursing and valued it

as learning material, they were able to identify the importance of their physical and emotional labour to patients. Findings suggested that patients judged the quality of nursing by the emotional style in which it was given, irrespective of their diagnosis and technical care required. However, experience with the quality patient care scale (QualPacs) and participant observation confirmed that quality of nursing was extremely difficult to measure objectively. Strauss et al's (1982b) classification of sentimental work offered a conceptual framework for describing the type of emotional labour that nurses undertook.

The characteristics of a 'good' ward learning environment according to nurses were found to be based on the assumption that formal teaching was necessary for learning to take place. Despite the predominance of this formal teaching/learning paradigm, students described the ward rather than the classroom as the place where most of their learning took place, and the ways in which they learnt as informal.

The relationship of quality of nursing and the ward learning environment was explored and explained by three hypotheses or clusters of conceptual categories. These hypotheses suggested that the quality of nursing and student learning on a ward were influenced by the nature of the work and the learning material, the sister's management style and the students' personal and learning trajectory. The findings pertaining to each conceptual category are summarised below.

The nature of the work and the learning material

Findings suggest that students associated 'good' learning environments with wards that had a high patient turnover, and patients with a variety of diagnoses requiring acute, technical nursing and specialist medical intervention. Wards that had a higher percentage of elderly patients with chronic medical conditions and high dependency were viewed less favourably by students as providing good learning environments. Despite identifying technical nursing and specialist

medical intervention as valuable to their learning, students associated quality nursing with those wards where the affective components of nursing were both visible and valued by the sister and trained staff.

The students identified oncology wards as wards where they learnt about affective as well as technical nursing. It appeared that the medical specialty of oncology legitimised caring for patients' affective as well as technical needs. Even when ward sisters were committed to making patients' affective needs visible and to valuing emotional labour, students did not identify the care of patients' affective needs as either work or learning material if they were generated from patients who were either elderly, physically dependent or suffering from general medical conditions. Physical labour was recognised as work on all wards but not as learning material, except for students at the beginning of training.

Since meeting patients' affective needs was recognised as neither work nor learning material (unless legitimised by a medical specialty), students did not believe that they needed to be taught how to do emotional labour. Rather, they believed that they were able to meet patients' affective needs because of their interest in people which had brought them into nursing.

Except for their first ward allocation 'where everything is valuable', the students' views of what was to be learnt in order to become qualified nurses reflected a medically orientated approach to nursing rather than the caring role prescribed by the nursing process which emphasises patients' physical and affective needs.

The promotion of the nursing process as a problem solving, individualised approach to patient care was not evident in the students' school based teaching programmes and ward based learning objectives. The students described the nursing process as a work method rather than in conceptual terms and as a means of carrying out patient

centred tasks. Consequently, they did not accept it as a viable means of gaining knowledge and acquiring skills, preferring instead to use a medical rather than a nursing approach to patient care.

The students recognised that the nursing process promoted a people orientated approach to patient care. On the one hand they saw it as more appropriate to those wards where they considered that patients required affective nursing, such as on oncology wards, or assistance with physical needs such as on geriatric wards. On the other hand they saw it as impracticable when the workload was physically demanding or acute and the staffing levels low.

The tutors expressed verbal commitment to the nursing process as a device for teaching and learning nursing. However they had no theoretical framework on which to base their teaching of the nursing process. For example, there was no evidence to suggest that they were using nursing models and 'theories' as a means of conceptualising nursing (Aggleton and Chalmers 1986). In practice the tutors fell back on, and their teaching programmes were overshadowed by, subjects that promoted the acquisition of medical knowledge and technical skills. The tutors presented idealised versions of nursing that held little credibility with students and reflected the tutors' limited clinical involvement. The students and ward staff identified the tutors as having primary responsibility for student teaching in ward and classroom and wanted them to have more clinical involvement in the wards.

Ward management styles

Sisters and trained staff who were regarded by students as demonstrating favourable management styles were described as happy; approachable; interested in students as people; accessible both in physical and personal terms; giving positive feedback, which made students feel appreciated; clear about what they expected from students as well as encouraging initiative; and allowing students to be involved

in decision making and discussion about patient care.

Students valued ward sisters who showed that they cared about patients by talking to them and their relatives and staying on duty longer than they should, to do this. Management styles that created positive ward atmospheres and staff relations motivated students to care more for patients. Some ward sisters created stress or anxiety for students and staff nurses through their management styles by being unappreciative and/or critical. According to the students, patients sensed an unhappy atmosphere and unhappy nurses created by the sister.

Sisters who were approachable and accessible and demonstrated a 'caring' approach to patients and students, through recognising patients' affective needs and the need to do emotional labour, were more likely to interpret the nursing process as a way of involving students in decision making and discussion about patient care through a verbal and written reporting system that involved all grades of staff. An explicit commitment to the nursing process appeared to be associated with sisters who valued interpersonal communication with patients and nurses, interpreted as the recognition of patients' affective needs and doing emotional labour.

The characteristics of the 'good' nurse valued by patients bore similarities to some of the characteristics of sisters and trained staff regarded by students as demonstrating favourable management styles both towards themselves and patients, that is, being happy, cheerful, and showing interest in others.

Positive learning environments were described by students as 'enjoyable', 'good', 'helpful', 'useful' or 'interesting'. Ward management styles were an important factor in how students felt about a ward experience, especially in terms of meeting their emotional needs and alleviating stress.

Since the major part of learning appeared to be informal, ward

management styles that made trained staff accessible and approachable to students were important for the provision of learning opportunities and making learning experiences 'intelligible'. The provision of formal teaching appeared to be less dependent on accessible and approachable management styles but more on the amount of 'structure' the sister imposed on her activities with other nurses.

Students as workers and learners

Students were the primary workforce and saw their ward activities as work which they might also identify as learning material depending on ward specialty and stage of training. Third year students were the hub of the service and numerically constituted the largest group of nurses allocated to the wards at City hospital. Stage of training was also important in determining what a student was expected to do, irrespective of the content of previous ward experiences. Third year students identified key procedures (such as managing a cardiac arrest, 'last offices' and passing a naso-gastric tube) which they hoped to be able to perform by the end of training. They also valued being able to gain management and teaching experience and expected to supervise junior students at the bedside, rather than being supervised themselves.

First year students frequently cared for dependent elderly patients in whom they invested substantial amounts of emotional labour. They were also more likely to spend time talking to patients than were more senior nurses, but did not have the experience nor the supervision to manage complex emotional encounters.

Student learning was also influenced by their personal and emotional needs throughout training. The findings show, however, that first year students were seen to be given more emotional support than students in their third year. The latter also wanted more emotional support, especially at the beginning of their final year of training when they felt anxious, uncertain and were going through a 'blues time'. Students

quickly began to work by themselves in caring for patients and saw this as necessary in order to become more confident. Whilst resenting lack of support from trained staff, students, even when very junior, still felt the need to be seen to cope alone in caring for patients.

Student learning was shaped by the hierarchical structure within nursing which determined not only whom the students worked with, but also whom they learnt from. They preferred to work with other students rather than with trained staff. Students believed that they were best able to learn from others who did not threaten them hierarchically and also did emotional labour on their behalf. Third year students as a group were most frequently identified in this way.

The practice of the nursing process

The study also aimed to assess the extent to which the nursing process had become part of the learning and practice of nursing. As discussed above, the nursing process was not recognised by students as an alternative knowledge base to a medically orientated one. Nor did the tutors use it as a device for teaching students about nursing.

The nursing process was interpreted by ward staff and students as a work method. The importance of patient rather than task allocation was recognised as students caring for groups of patients rather than carrying out series of tasks. They also described the nursing process as a people orientated approach to nursing and as such recognised its underlying ideology of patient centred, affective care. However, in practice, the system of patient allocation in operation on the wards at City hospital served to fragment patient and nurse contact. Following Menzies (1970), a possible explanation for fragmentation of care in this way was that nurses were protected from becoming too emotionally involved with patients or each other in the absence of structures to enable them to do so. The findings of the present study demonstrated that the implementation of the nursing process demands a greater

recognition of communication and encounter as the central work relationship and the need to support nurses in doing emotional labour. Although at the City hospital junior students did give continuous care to long term elderly patients, it was without adequate supervision and support from trained staff, especially in relation to emotional labour.

Emotional labour and the nursing labour process

As stated in chapter 2, section 2.1.1 (see p.31), of this thesis, Hochschild (1983) defines emotional labour as:

... the induction or suppression of feeling in order to sustain an outward appearance of calm that produces in others a sense of being cared for in a convivial safe place. (p.7)

According to Hochschild, jobs which involve emotional labour share three characteristics:

- 1) Face to face contact with the public;
- 2) They require the worker to produce an emotional state in another, e.g. gratitude, fear;
- 3) They allow the employer through training and supervision to exercise a degree of control over the emotional activities of the employee.

The findings of the present study have shown that in relation to characteristics (1) and (2), patients judged the quality of nursing by the emotional style in which it was given. Similarly, students judged the quality of the ward learning environment by the sister's emotional style of management. Ward sisters who made visible the care of patients' affective needs and who valued emotional labour showed similar concern for students. The relationship between the quality of nursing and the ward learning environment appears to be articulated through the sister's emotional style of management which made her approachable and accessible and facilitated students' learning and feelings of wellbeing.

The findings also show that nurses at the City hospital were selected and supervised through ward based assessments to do emotional labour, but were inadequately trained to manage complex feelings. The hierarchical system of health care, together with inadequate training

in the handling of complex feelings, appeared to permit the withdrawal of emotional labour and to deflect the onus to carry it out, to the junior student members of the nursing staff. They in turn withdrew emotional labour when it was neither recognised nor valued by trained nurses.

Implications and recommendations

Hochschild (1983) found that certain conditions, such as reduction in staffing levels and quicker turnaround of flights, militated against the production of emotional labour. Similarly, in the NHS, the cutback of resources on an already limited resource allocation circumscribes the amount of emotional labour that nurses are able to do. Furthermore, nurses are amongst lower income workers and their salaries do not reflect payment for the emotional component of their labour. By comparison, flight attendants' higher wages represent the airlines' recognition that the production of emotional labour has financial implications, since passengers are more likely to use an airline where emotional labour is explicit. It is interesting to speculate as to whether the Thatcher government (1979 - present), with its commitment to privatisation of the public sector, will lead to a commercialisation of nurses' emotional labour in the private health industry. Already the images used for advertising private health insurance bear similarities to those used by the airline industry for attracting custom.

These images offer an attractive alternative to the long waiting lists, overworked staff and crumbling installations of the present day National Health Service. Since its inception in 1948, the NHS has always been under resourced and its staff underpaid. The emotional component of caring has never been recognised nor financially rewarded, but especially in the prestigious teaching hospitals, such as City, it was not seen as important because there were always enough recruits to nursing. Now, as the present study reaches its conclusion (1987),

demographic changes have resulted in a reduction of the number of eighteen year old girls and a nursing recruitment crisis (Committee of Public Accounts 1987).

There is also evidence to suggest that nurses are leaving the NHS because they are becoming increasingly dissatisfied with what they are able to do physically and emotionally for patients under the present conditions. Correspondence in the Guardian newspaper in 1985 bears witness to this. The first piece of correspondence (Pearmain 1985) was a letter from the father of a student nurse in a London teaching hospital who had just dissuaded her from discontinuing her training. The correspondent noted that it was neither poor pay nor long hours that had driven his daughter to consider leaving, but 'the sheer lack of opportunity to nurse in the true sense, that has totally demoralised her'. He described poor staffing and high workload in the following way: 'students were allocated between 12 and 15 patients each', many of whom were 'ill and frail'. Nurses were also taking on extra duties because of the lack of ancillary staff. The correspondent also noted that there was no time available for ward based training, with the result that his daughter and her colleagues were being transformed into 'objects of cheap labour'. Consequently many of them had left nursing. The father concluded that the ever growing cutbacks in the NHS would probably compel his daughter to leave once she had qualified, since the prevailing conditions prevented her from being a 'good nurse'. A reply to this letter by a district nurse supported its contents when she said: 'Occasionally it is still possible to experience a sense of achievement, of a job well done. But it is too rare to be complacent' (Black 1985).

The findings from a study of job satisfaction amongst student nurses provides research evidence to back up the experiences described in the Guardian correspondence (West and Rushton 1986). The students' overall

satisfaction levels were significantly lower than those of workers in other occupations. Reasons for their dissatisfaction included 'strained atmospheres' and unacceptable hierarchical relationships with nurses senior to themselves and doctors. The students also felt 'bad' when they were unable to do their jobs properly despite high personal commitment to do them well. A student on her fifth day of training wrote in a data diary: 'allocated eight patients to care for, three with intravenous drips. I felt really under pressure of not feeling competent enough' (West and Rushton, p.31). Students also expressed stress and frustration because of the lack of feedback on their job performance and too little freedom within their work, a finding which also occurred in the present study. The combination of factors led students to drop out of training.

An article in the Independent newspaper (Timmins 1987) reported the findings of a study which discovered that trained staff, especially those with specialist skills, are also leaving the NHS, and are abandoning it for the more attractive conditions of the private sector. The study concluded that the drift of staff to the private sector could be prevented if the NHS conditions were made more attractive for nurses.

The need to recognise and support the emotional and physical components of caring advocated by McFarlane (1976) becomes even more urgent in the battered NHS of the 1980s. However, there is already a tendency that the technical skills of nurses such as those working in theatre and intensive care will be given financial incentives to stay in the NHS. The physical and emotional labour demanded by elderly and chronically ill patients continues to go unrecognised by politicians and nurses themselves. The present study suggests that in order to go beyond the rhetoric of nursing leaders it is necessary to redefine nursing work, learning material and the way in which nurses learn.

As reviewed in chapter 2, feminist research explains why technical nursing holds higher status as work and learning material than physical and affective nursing. Both physical and affective aspects of nursing, like any care work, are taken for granted as something that women automatically do and derive fulfilment from. Oakley (1974) and Ungerson (1983b) have both described women's work related to mothering and housewifery as a 'set of skills'. Of particular relevance to a study of nursing are those skills related to social interaction and time management. Many of the skills associated with women's work, such as the creation of a positive ward atmosphere, approachability, accessibility, ability to communicate, were described by students in the present study as important components of quality of nursing and ward learning environments. These components were not readily identified as work, however, nor as learning material unless legitimised by the medical specialty of oncology. Students recognised that they learnt such skills informally from observing other people who were adept at them. These skills were clearly identified by the students as 'caring' skills.

However, the predominant teaching/learning paradigm held by students in the study presupposed that formal teaching was necessary for learning to take place. The students also assumed that the knowledge they needed to become nurses was based on medical facts.

The findings of this study suggest the need to re-examine traditional definitions of knowledge and teaching/learning paradigms. Collins (1974), for example, asserts that all types of knowledge, however 'pure', partly consist of 'tacit' rules which may be impossible to formulate. Collins suggests that the process of learning or building up tacit understanding is like learning a language or a skill. Eraut (1985), quoting Oakeshott (1962), distinguishes between 'technical' and 'practical' knowledge. The former can be written and codified; the latter is expressed only in practice and learned through practical

experience. Eraut gives examples of practical knowledge 'which is essentially non-verbal - the tone of voice or musical instrument, the feel of a muscle or piece of sculpture, the expression on a face' (p.119). Eraut's description of practical, uncodified knowledge is similar to that of Collins' notion of tacit rules. Both notions are relevant to a redefinition of nursing knowledge in terms of its physical and affective components and in relation to what and how students learn on the wards. These components also correspond to Sheehan's (1983) suggestion that the teaching-learning process in nursing should integrate intuitive insights with systematic knowledge.

Godwin (1983) makes similar recommendations for the teaching of rural health workers in Kenya. These recommendations are particularly pertinent to an NHS under attack. Firstly, he recommends that the acquisition of technical knowledge is insufficient without an emphasis on problem solving skills which takes into account the practical realities of limited resources. Secondly, he recommends that teachers value and use students' experiences of the real world of practice. Teachers, therefore, must be confident and conversant with clinical practice and be able to facilitate learning from the experiences available to students as they work together.

Melia's (1984) finding that student nurses did not follow a true apprenticeship is relevant here. According to Melia, nurse training is marked by discontinuity in that students are not guaranteed instruction by trained nurses. Their rapid movement from ward to ward and shift to shift also militates against them working with the same nurse for any length of time. These findings were confirmed in the present study.

In the light of the discussion on knowledge, teaching and learning, the findings of this study suggest the need for students to be allocated to a qualified and experienced nurse throughout training. This nurse would act as a facilitator, monitoring, interpreting and planning

their learning experiences and responding to their individual and learning needs. The nature of the facilitator-student relationship would be open and non-hierarchical and students would be provided with feedback on their progress. The facilitator would move between classroom and ward and be involved in patient care together with students. In this way, quality of nursing would be assured. Students would learn to recognise the affective and physical components of nursing as work and learning material with teachers who made these experiences intelligible, in the same way as technical nursing. The facilitator would also care for the students' emotional needs and provide them with a support system to enable them to do emotional labour.

Findings of this study also suggest that although the medical profession shapes the content of nurses' work and students' learning material, the way in which a sister manages her ward and prioritises her work is a matter of personal preference. Fretwell (1982) reported similar findings. Since their emotional style of management was found to be critical to quality of nursing and the ward learning environment sisters, like students, require support and feedback on the way they manage their ward. If better measures of quality of nursing are to be developed, they will need to take into account the sister's emotional style of management and support network.

Given the demographic changes and recruitment crisis in nursing, recruitment and retention will continue to deteriorate unless conditions of work and salaries improve. Nurses will continue to vote with their feet and leave the NHS and nursing. Already, suggestions to meet the staffing crisis include the recruitment of untrained support workers, partly through the government's youth training schemes (DHSS 1987), which to many observers appears to be proposing ways of providing nursing 'on the cheap'. The findings of this study suggest that, until the importance and complexity of emotional labour to the quality

of nursing and the ward learning environment is recognised, supported and adequately rewarded, any recommendations for change will be limited.

APPENDIX 1: RESEARCH PROTOCOLS

Nursing research project: Factors affecting student nurse learning and patient care

STUDENT NURSES

During your allocation to this ward, I shall be carrying out some ward based research for a project that you may have heard about, which is looking at factors affecting student nurse learning and the relationship of nursing theory to practice.

For some of the time that I am on the ward, I shall be working as a nurse. I shall also be talking to selected patients prior to discharge and spending two or three days observing the numerous activities that take place during a two hour period.

In all I shall be on the ward two to three shifts per week over eight weeks. Please feel free to ask any questions you have about the project and to make any comments. All information collected on the ward will be anonymous and treated confidentially.

The outcome of the project will depend on the findings, but it is possible that recommendations will be made for bringing the learning and practice of nursing closer together.

Pam Smith, Senior Nurse (Research)
November 1984

PATIENTS

Whilst you are in hospital, I shall be carrying out some ward based research for a project that is looking at how student nurses learn to nurse.

For part of the time that I am on the ward, I shall be working as a nurse. I shall also be talking to a sample of patients prior to discharge and spending two or three days observing the numerous activities that take place during a given two-hour period. In all I shall be on the ward two to three shifts per week.

Please feel free to ask any questions about the project and to make any comments. All information collected on the ward will be anonymous and treated confidentially.

The outcome of the project will depend on the findings, but it is hoped that it will benefit staff and patients.

Pam Smith, Senior Nurse (Research)
November 1984

APPENDIX 2: STUDENT INTERVIEW AGENDA

INTERVIEW

Selection for interview
Family background
Willingness to participate
Age
Direct entry from school or prior experience

GENERAL OVERVIEW

Match between reality and expectations of nursing
Role change over three years

'THEORY' AND 'PRACTICE'

The knowledge base of nursing
The application of classroom teaching to ward practice

TEACHING AND LEARNING

Content and methods of learning on the wards: people and situations

THE WARDS

Ward organisation and learning
The nursing process
Quality of nursing

TRAINING REQUIREMENTS

Objectives, assessments, ward reports, written assignments
Patterns of ward allocation and stage of training
Duration of ward placements

THE SCHOOL OF NURSING

The role of the school of nursing
The role of the nurse teacher

APPENDIX 3: TUTOR INTERVIEW AGENDA

BACKGROUND

Path to becoming a nurse teacher
Reasons for becoming a nurse teacher

GENERAL OVERVIEW

Views on nurse training

'THEORY' AND 'PRACTICE'

The knowledge base of nursing
The nursing process
The application of classroom teaching to ward practice

TEACHING AND LEARNING

Students' learning needs at different stages of training
Creating the conditions for learning in the classroom and ward

THE WARDS

Ward organisation and learning
Quality of nursing

THE SCHOOL OF NURSING

The role of the school of nursing
The role of the nurse teacher
Meeting students' emotional needs

APPENDIX 4: WARD SISTER INTERVIEW SCHEDULE

APPENDIX 4(a): THE RESOURCES OF THE WARD SISTER (Pembrey 1980)

Number of beds

Number of consultants

Senior registrars

Registrars

SHO/House officers

Number of SRNs - full-time/part-time

Average number of students

Night staff - internal rotation

Designated senior staff nurse (out of night duty rota) (yes/no)

Ward clerk - hours per week

- Works a.m./p.m.

Clinical teacher - hours per week

How long, on average, do the nurses stay?

Trained staff (number of months)

Learners (number of weeks)

Any influence over selection of trained staff?

Nursing meetings?

Other professional commitments?

APPENDIX 4(b): SISTERS' SEMI-STRUCTURED INTERVIEW SHEET (Pembrey 1980)

Date

Hospital/Sister/Ward

Please outline typical day/how nursing is organised (1st shift)

How do the nurses know what to do?

What work do the different nurses do?

How do they work?

How do you find out what work has been done?

Supplementary questions for present study:

¹Contact with the school of nursing?

What do students learn during their allocation to your ward?

How do students learn on your ward?

What are students' learning needs at different stages of training?

APPENDIX 5: PATIENTS' INTERVIEW GUIDE (Coser 1962)

1. When you're sick, would you rather be at home or in hospital?
2. What do you miss most while you're in the hospital?
3. What is your idea of a good doctor?
4. What is your idea of a good nurse?
5. What is your idea of a good patient?
6. How do you like the rounds?
7. How do you like the ward?
8. Are there any suggestions that you would care to make for a possible improvement of the patients' comfort?
9. Are you ever bored or restless while you're in the hospital?
10. What will be the first thing you'll do when you get home?

APPENDIX 6: CHECKLIST OF DAILY WORK PRIORITIES (Pembrey 1980)

A ward sister/charge nurse has a great number of different jobs to do each day. Please read through the list and tick the jobs you feel are the important ones for you to do. Then please read through the list of jobs you have ticked and place an extra tick against the jobs you feel are the most important ones for you to do.

The important daily jobs for me to do are:

1. Supervise the patients' meals
2. Accompany the consultant on his round
3. Work with a student/auxiliary
4. Write up the nursing kardex
5. Give some nursing care to patients
6. Allocate the work at the beginning of the shift
7. Ask the nurses to report on their work
8. Do a nursing round of patients
9. Give the nurses a report on the patients
10. Order stores/equipment

Are there other tasks you would do each day? If so, please list below:

Ward sisters/charge nurses sometimes feel they have not enough time for some parts of their work. Are there some aspects of your work that as a ward sister/charge nurse you would like to give more time to?

APPENDIX 7: CHECKLIST OF WORK PROBLEMS (Pembrey 1980)

A ward sister's work always has a number of problems which make the job more difficult, or stops you from doing it as you would like. Please read through the list and for each item tick whether it is a problem, or is not a problem, for you.

In your job as a ward sister is this a problem? (yes/no)

1. Getting extra help when the ward is very busy
2. Doctors not giving patients enough explanation
3. Being unable to complete one job at a time
4. Admissions arriving in the ward before their beds are ready
5. The design of the ward
6. Student nurses allocated for too short a time
7. Getting conflicting orders from different doctors
8. Not enough nurses who can supervise or teach
9. The number of patients who are transferred to or from the ward
10. Getting patients notes or X-rays
11. The feeling that you have no one really to turn to for help
12. Having to lend nurses to other wards
13. The number of dependent/handicapped patients
14. Having to have extra beds in the ward
15. Interruptions from doctors
16. Arranging the off duty to give adequate ward cover
17. Getting ward furniture/equipment repaired or replaced
18. Trained staff moving frequently
19. The number of tests the doctors order
20. Interruptions from the telephone
21. Getting the ward cleaned properly
22. Nurses going off sick for the odd day or so
23. The number of separate medical rounds in the day
24. Interruptions from the nurses
25. Patients being discharged at too short a notice
26. Being given, or having to keep, unsatisfactory staff nurses
27. Getting doctors to keep to the hospital drug rules
28. People always coming to the ward sister
29. Patients who should really be in other wards
30. Getting enough linen

Other problems (please specify)

PRIVATE AND CONFIDENTIAL

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WARD LEARNING ENVIRONMENT RATING QUESTIONNAIRE

Ward Student ☐ Pupil ☐ Trained Nurse ☐
(Please tick)

The following statements are concerned with nurse training in the ward. For each statement please indicate your opinion by placing a tick (✓) in one of the five boxes. There are no right or wrong answers, but please try to avoid the 'uncertain' column unless you really cannot agree or disagree. If you wish to clarify or explain your choice, make your comments in the box provided.

Note: The term 'learner' is intended to include both student and pupil nurses.
'Sister' applies equally to charge nurses.

SECTION A (Questions 1 to 3 to be answered by student and pupil nurses only)	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Comments
1. This was a good ward for student/pupil learning.						
2. I am happy with the experience I have had on this ward						
3. I learnt very much on this ward.						
(Remaining questions to be answered by everyone)						
4. The number of staff is adequate for the workload.						
5. There is very much to learn on this ward.						
6. There are enough trained nurses in relation to learners and auxiliaries.						
7. The workload does not interfere with teaching or learning.						

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and: - West Midlands Regional Health Authority.

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SECTION B. WARD ATMOSPHERE/STAFF RELATIONS

On this ward, the sister and trained nurses:-

- | | Strongly Agree | Agree | Uncertain | Disagree | Strongly Disagree | Comments |
|--|----------------|-------|-----------|----------|-------------------|----------|
| 8. Provide an atmosphere which is good to work in. | | | | | | |
| 9. Are concerned about what a student is thinking or feeling. | | | | | | |
| 10. Are available and approachable. | | | | | | |
| 11. Give reprimands in private | | | | | | |
| 12. Praise and encourage the learner in her work | | | | | | |
| 13. Work as a team with learners. | | | | | | |
| 14. Keep staff and learners well informed about ward activities. | | | | | | |

SECTION C. WARD TEACHING

- | | | | | | | |
|---|--|--|--|--|--|--|
| 15. Sister devotes a lot of her time to teaching learners. | | | | | | |
| 16. Trained nurses on the ward teach regularly. | | | | | | |
| 17. Clinical teachers teach regularly on the ward. | | | | | | |
| 18. Consultants are interested in teaching. | | | | | | |
| 19. There are regular sessions, in which trained nurses discuss the nursing care of patients. | | | | | | |
| 20. The ward report is used as an occasion for teaching learners. | | | | | | |
| 21. Trained nurses teach as they work with learners. | | | | | | |
| 22. Sister initiates teaching | | | | | | |
| 23. Learning objectives are in use on this ward. | | | | | | |
| 24. Sister accords teaching and learning activities a place in the routine. | | | | | | |

38. What work and other experiences on this ward were most valuable for your education?

38. What work and other experiences on this ward were most valuable for your education?

39. What work and other experiences were least valuable for your education?

40. Have you any suggestions for improving teaching and learning on this ward? If so please give details.

41. In case you have any other comments to make about the ward, would you write them below

THANK YOU FOR YOUR CO-OPERATION

THANK YOU FOR YOUR CO-OPERATION

QUALITY PATIENT CARE SCALE INFORMATION FACE SHEET

Patient	Unit
Name _____	Name _____ Type _____
Record # _____	Number of Rooms _____
Room # _____ Accommodations _____	Number of Beds _____
Admission Date _____	Census _____
Diagnosis: _____	LEVELS OF CARE (Number of patients in each)
Admission _____	A _____ C _____ E _____
_____	B _____ D _____
_____	PERSONNEL CODE AND CENSUS
Current _____	Registered Nurse _____ R _____
_____	Practical Nurse _____ P _____
_____	Nursing Student _____ SN _____
_____	Practical Nursing Student _____ PN _____
_____	Instructor _____ I _____
Condition of Patient _____	Head Nurse _____ H _____
_____	Candy Striper _____ C _____
_____	Supervisor _____ S _____
_____	Orderly _____ O _____
_____	Ward _____ W _____
_____	Aide _____ A _____
_____	Unknown Initiator _____ U _____

OTHER PERTINENT DATA:

Date _____	Rate _____
Time of Day _____ AM/PM	INTERACTIONS _____
REPORTS: Change of Shift _____	OUTCOMES: Total Item Mean Score _____
Team _____	Total of Items Used _____
Other _____	Score (Mean of Means) _____

Additional notes or questions:

APPENDIX 9

Appendix

1. INFORMATION FACE SHEET

2. RATER'S NOTES

3. QUALITY PATIENT CARE SCALE

Contact the publisher for information regarding use and reproduction of the forms in this section in connection with use of the Qualipaqs

Permission sought from the publisher to use this form.

QUALITY PATIENT CARE SCALE

Patient (name or No.):

Plater Name or No.):

Qualifiers

Poster Name or No.):

INTERACTIONS RECORD: AM/PM

ASSESSMENT AND PLANNING CARE

FOR

ASSESSMENT AND PLANNING CARE

PATIENT

ORDERS, NEEDS, NURSING ACTIONS

Diet (meals, fluids, nourishment)

Medications

Treatments (dressings, irrigations)

Special care:

- a. colostomy, trach., etc.
- b. skin-bath, lotion, etc.
- c. traction, cast
- d. decubiti

Observation of condition

- a. Direct
- b. Monitors (V.S., Pacemakers, etc.)

Diagnostic Tests

- a. On ward
- b. Off ward

Activity (bedrest, ambulation, etc.)

Sensory deficit (blind, aphasic, deaf)

Safety

Teaching patient and family

Socialization and diversion

Multiple services (referrals, consultations)

Reporting and recording

Planning for continuity of care

Other

PSYCHOSOCIAL: INDIVIDUAL

Actions directed toward meeting psychosocial needs of individual patients

1. Patient receives nurse's full attention. # D
2. Patient is given an opportunity to explain his feelings. = D
3. Patient is approached in a kind, gentle, and friendly manner. = D
4. Patient's inappropriate behavior is responded to in a therapeutic manner. = D
5. Appropriate action is taken in response to anticipated or manifest patient anxiety or distress. # D/°
6. Patient receives explanation and verbal reassurance when needed. = D
7. Patient receives attention from nurse with neither becoming involved in a nontherapeutic way. # D
8. Patient is given consideration as a member of a family and society. # D/°
9. Patient receives attention for his spiritual needs. # D/°

		MEAN SCORE	NOT OBSERVED	NOT APPLICABLE	POOREST CARE BETWEEN	AVERAGE CARE BETWEEN	BEST CARE ITEM NUMBER
		17-19	20-22	23-25	26-28	29-31	32-34
Needs	1						
In his	2						
Friendly	3						
To In a	4						
Metic-	5						
# D/#1	6						
Insurance	7						
Neither	8						
# D	9						
er of a							
needs.							

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
10								29-30
11								31-32
12								33-34
13								35-36
14								37-38
15								39-40
AREA I MEAN								41-42-43

10. The rejecting or demanding patient continues to receive acceptance. # D/1
11. Patient receives care that communicates worth and dignity of man. # D
12. The healthy aspects of the patient's personality are utilized. # D/1
13. An atmosphere of trust, acceptance, and respect is created rather than one of power, prestige, and authority. # D
14. Appropriate topics for conversation are chosen. # D
15. The unconscious or nonoriented patient is cared for with the same respectful manner as the conscious patient. # D

PSYCHOSOCIAL: GROUP

- Actions directed toward meeting psychosocial needs of patients as members of a group.
16. Patient as a member of a group receives warmth, interest, and attention from the staff. # D
 17. Patient receives the help necessary to accept limits on his behavior that are essential to group welfare. # D
 18. Patient receives encouragement to participate in or to plan for the group's daily activities. # D
 19. The member of the group is provided with the opportunity to assume responsibility according to his capability. # D

16								44-45
17								46-47
18								48-49
19								50-51

20								52-53
21								54-55
22								56-57
23								58-59
AREA II MEAN								60-61-62

20. Staff proposals for patient activities appropriately reflect interests and needs of the group members. # D
21. Patient is helped to vent his emotions in a socially acceptable way within the group. # D
22. Praise and recognition are given for achievement according to individual needs and with respect for others in the group. # D
23. The rights and integrity of the group member are protected within the group structure. # D

PHYSICAL

- Actions directed toward meeting physical needs of patients.
24. Nursing procedures are adapted to meet needs of individual patient for treatment. # D
 25. Patient's daily hygiene needs for cleanliness and acceptable appearance are met. # D
 26. Nursing procedures are utilized as media for communication and interaction with patient. # D
 27. Physical symptoms and physical changes are identified and appropriate action taken. # D
 28. Physical distress evidenced by the patient is responded to quickly and appropriately. # D
 29. Patient is encouraged to observe appropriate rest and exercise. # D/1

24								63-64
25								65-66
26								67-68
27								69-70
28								71-72
29								73-74

ITEM NUMBER	BEST CARE	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
30							76-78
31							77-78
32							79-80
33							11-12
34							13-14
35							15-16
36							17-18
37							19-20
38							21-22
AREA III MEAN							23-24-25

30. Patient is encouraged to take adequate diet. # D/°
31. Action is taken to meet the patient's needs for adequate hydration and elimination. # D/°
32. Behavioral and physiologic changes due to medications are observed and appropriate action taken. # D/°
33. Expectations of patient's behavior are adjusted and acted upon according to the effect the medication has on the patient. # D/°
34. Medical asepsis is carried out in relation to patient's personal hygiene and immediate environment. # D
35. Medical and surgical asepsis is carried out during treatments and special procedures. # D/°
36. Environment is maintained that gives the patient a feeling of being safe and secure. # D
37. Safety measures are carried out to prevent patient from harming himself or others. # D
38. Established techniques for safe administration of medications and parenteral fluids are carried out. # D

GENERAL

Actions that may be directed toward meeting either psychosocial or physical needs of the patient or both at the same time.

39. Patient receives instruction as necessary. # D

39							26-27
----	--	--	--	--	--	--	-------

ITEM NUMBER	BEST CARE	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
40							28-29
41							30-31
42							32-33
43							34-35
44							36-37
45							38-39
46							40-41
47							42-43
48							44-45
49							46-47
50							48-49
51							50-51

40. Patient and family are involved in planning for care and treatment. # D/°
41. Patient's sensitivities and right to privacy are protected. # D
42. Patient is helped to accept dependence/interdependence as appropriate to his condition. # D
43. Resources within the milieu are utilized to provide the patient with opportunities for problem solving. # D
44. Patient is given freedom of choice in activities of daily living whenever possible and within patient's ability to make the choice. # D
45. Patient is encouraged to take part in activities of daily living that will stimulate his potential for positive psychosocial growth and movement toward physical independence. # D/°
46. Activities are adapted to physical and mental capabilities of patient. # D/°
47. Nursing care is adapted to patient's level and pace of development. # D
48. Diversional and/or treatment activities are made available to the patient according to his capabilities and needs. # D
49. Patient with slow or unskilled performance is accepted and encouraged. # D
50. Nursing care goals are established and activities performed which recognize and support the therapist's plan of care. # D/°
51. Interaction with the patient is within framework of the therapeutic plan. # D

ITEM NUMBER	BEST CARE	BETWEEN AVERAGE CARE	BETWEEN POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
52						52-53
53						54-55
AREA IV MEAN						56-57-58

52. Close observation of the patient is carried out with minimal disturbance. # D

53. Response to the patient is appropriate in emergency situations. # D

COMMUNICATION

Communication on behalf of the patient.

54. Ideas, facts, feelings, and concepts about the patient are communicated clearly in speech to medical and paramedical personnel. # D

55. Family is provided with the opportunity for reciprocal communication with the nursing staff. # D

56. Ideas, facts, and concepts about the patient are clearly communicated in charting. #

57. Well-developed nursing care plans are established and incorporated into nursing assignments. #

58. Pertinent incidents of the patient's behavior during interaction with staff are accurately reported. # D

59. Staff participate in conferences concerning patient care. # D

60. Effective communication and good relationships with other disciplines within the hospital are established for the patient's benefit. # D

54						59-60
55						61-62
56						63-64
57						65-66
58						67-68
59						69-70
60						71-72

ITEM NUMBER	BEST CARE	BETWEEN AVERAGE CARE	BETWEEN POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
61						73-74
AREA V MEAN						75-76-77

61. Patient's needs are met through the use of referrals, both to departments in the hospital and to other community agencies. # D

PROFESSIONAL IMPLICATIONS

Care given to patient reflects initiative and responsibility indicative of professional expectations.

62. Decisions that are made by staff reflect knowledge of facts and good judgment. # D

63. Evidence (spoken, behavioral, recorded) is given by staff of insight into deeper problems and needs of the patient. # D

64. Changes in care and care plans reflect continuous evaluation of results of nursing care. # D

65. Staff are reliable: follow through with responsibilities for the patient's care. # D

66. Assigned staff keep informed of the patient's condition and whereabouts. # D

67. Care given the patient reflects flexibility in rules and regulations as indicated by individual patient needs. # D

68. Organization and management of nursing activities reflect due consideration for patient needs. # D

62						78-79
63						81-82
64						83-84
65						85-86
66						87-88
67						89-90
68						91-92
AREA VI MEAN						93-94-95
Sum of Item Means						
Number of Items Rated						
Mean of Item Means						96-97-98

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